

*A Health Service of all the talents:
Developing the NHS workforce*

Consultation Document on the Review of
Workforce Planning

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A Health Service of all the talents: Developing the NHS workforce

Consultation Document on the Review of Workforce Planning



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contents

Foreword	3
Executive Summary	5
Chapter 1: What are we trying to achieve?	9
Chapter 2: What do we mean by workforce planning?	12
Chapter 3: Current workforce planning arrangements	14
Chapter 4: Where do the problems lie?	19
Chapter 5: What is to be done?	26
Chapter 6: How to comment on this consultation document	41
Appendix A: Current medical workforce planning arrangements	42
Appendix B: Current workforce planning arrangements for other clinical staff	43
Appendix C: Proposed workforce planning arrangements	44

Foreword

In its report on NHS staffing requirements in March 1999 the House of Commons Health Select Committee recommended that there should be a major review of workforce planning in the NHS. The Government accepted this recommendation and set out a number of key principles which should govern the review:

- The NHS and the NHS Executive must be clear about service needs and the skills and staff required to deliver those services efficiently and effectively.
- Thinking about services, workforce and resources should be done together to ensure plans and developments are consistent and co-ordinated.
- There should be an appropriate mix between central (top-down) and local (bottom-up) planning.
- Planning should cover the whole healthcare workforce, looking across sectors (primary, secondary and tertiary), employers (public, private and voluntary) and staff groups (nurses, doctors, dentists, other professions and other staff) and should take account of evolving roles.
- Workforce planning arrangements should reflect clear and agreed responsibilities and accountabilities, with effective performance management systems.

The review, which was launched in September 1999, had the following Terms of Reference:

- To review workforce planning arrangements for all professional groups within the NHS
 - considering the roles and responsibilities for workforce planning at all levels within the NHS and the NHS Executive
 - exploring the opportunities and barriers which currently exist for effective and efficient workforce planning within the context of current related policy initiatives and known future changes likely to impact on the workforce.

The review team was to report to Ministers by the end of 1999, followed by the issue of a consultation document early in the New Year and the development of a clear action plan and work programme by summer 2000 in the light of consultation.

In taking forward the first phase of the review we have been guided by the general principles set out above. We have also sought the views of those currently involved in workforce planning or who are the customers of that planning. This has included professional bodies, trade unions, NHS management, patient organisations, education providers, staff in the NHS Executive and a range of individuals. We are grateful to all of them, and to those who submitted views in writing: without their willingness to contribute their time and thoughts it would have been impossible for us to have done our job.

We are also conscious that, in the time available, we have not been able to do full justice to the range of issues they raised with us. We should make clear that we recognise the considerable time and effort which

is being put in by many people to make the current planning arrangements work. While we make a number of recommendations for change, these should not be seen as critical of the individuals concerned, many of whom recognised the need to improve and develop those arrangements. Indeed many of the ideas for improvement came from those currently involved in workforce planning.

It is also important to be clear that this review was not primarily concerned with the numbers of staff needed by the NHS. We make recommendations for reviews in these areas but decisions here will need to flow from a fuller analysis of patient needs and take full account of the resources available to the NHS. Rather the review is concerned with the way in which the NHS workforce should be planned and developed to deliver the best possible service to patients.

We should stress that this review is concerned only with workforce planning and development in England. We have, of course, consulted colleagues in Scotland, Wales and Northern Ireland and we are aware that a similar review is being undertaken in Scotland, and one is planned in Wales at a later date.

Finally we should record our thanks to the staff of the Workforce Planning Branch of the NHS Executive, particularly Colin Day, Jane Hare and Julia Moore, for their help and support during this phase of the review.

Judy Hargadon
Martin Staniforth

April 2000

Executive Summary

Nearly 1 million people work for the NHS. We spend some £2 billion a year on supporting training and education for clinical staff – and more money is spent locally on staff development and training. We need to make sure that we plan and develop the NHS workforce, and use our investment in it, to deliver the best, most effective, care for patients. Because caring for people is what the NHS is all about.

This report stems from long-standing concerns about the way in which the NHS educates, trains and uses its staff. Its proposals and recommendations – which are summarised below – are wide-ranging and radical. But at their heart is a simple theme – that the NHS workforce, whose commitment no-one can doubt, needs to be transformed in order to provide the sort of care which will be needed in the future. The emphasis needs to be on:

- *team working* across professional and organisational boundaries;
- *flexible working* to make the best use of the range of skills and knowledge which staff have;
- *streamlined workforce planning and development* which stems from the needs of patients not of professionals;
- *maximising the contribution of all staff to patient care*, doing away with barriers which say only doctors or nurses can provide particular types of care;
- *modernising education and training* to ensure that staff are equipped with the skills they need to work in a complex, changing NHS;
- *developing new, more flexible, careers* for staff of all professions and none;
- *expanding the workforce* to meet future demands.

And we need to do this not just because it is the right thing to do but because it will provide patients with the care they have the right to expect. Care which is delivered quickly, by skilled professionals, who listen to them and provide the best possible treatment and care.

The NHS has dedicated, hard-working staff. We need more of them. The Government is committed to expanding the NHS by expanding the number of doctors, nurses and other health professionals. But alongside expansion must come reform, to change the way staff work, the way they are trained and how they are educated. Realising the potential of all NHS staff is our aim. We want a health service of all the talents.

The proposals and recommendations in this report, which is published for consultation, are aimed at helping to deliver the workforce the NHS now needs.

What are we trying to achieve?

Chapters 1 and 2 of the report set out briefly the reasons why the current workforce planning arrangements need to be changed in order to deliver the workforce which the modernised NHS requires.

Where are we now?

Chapters 3 and 4 of the report describe the current arrangements for workforce planning and the problems which need to be tackled. In particular current arrangements are not:

- Built around service needs and the skills required to deliver them.
- Well integrated with service and financial planning.
- Holistic in their approach, looking across primary, secondary and tertiary care or across staff groups.
- Responsive to service changes and developments.
- Supportive of multi-disciplinary training, education and working.

What changes need to be made?

In order to improve the present arrangements the review makes a number of proposals and recommendations covering four key areas. While some of its recommendations are firm and can, subject to consultation, be taken forward quickly, others will require more debate and discussion to agree the way forward.

Greater integration, more flexibility

The review recognises that current workforce planning and development arrangements inhibit the development of multi-professional planning and have not supported the creative use of staff skills. It stresses the need for:

- Greater integration of workforce planning and development with service and financial planning.
- More flexible deployment of staff to maximise the use of their skills and abilities.

It then makes a number of proposals to help achieve these aims, including:

- Workforce planning and development to be aligned with service planning at local level through the Health Improvement Programme (HImp).
- Workforce plans to be developed on a multi-disciplinary basis, focusing on services to be delivered and looking across primary, secondary and tertiary care.
- The establishment of a National Workforce Development Board, supported by Care Group Workforce Development Boards, to be responsible for ensuring the proper integration of workforce issues with service development taking account of skill-mix changes and research and development findings. It should incorporate the work of existing uni-professional groups.
- The merger of education and training levies to provide an integrated funding stream.
- Central action to co-ordinate work on skill-mix changes and the development of new types of healthcare worker.

Better management ownership, clearer roles and responsibilities

The review concludes that effective workforce planning and development requires greater clarity about responsibilities, proper management and clear systems of performance management. At employer level it is the responsibility of each NHS Trust or other local employer to develop workforce plans for their organisation and be held to account for their delivery. While these local plans provide a major input to national workforce planning they are not sufficient on their own. First, the NHS is not only the employer of healthcare professionals, and second, the time horizon for local planning is necessarily limited compared with, say, the time required to train doctors. The review recommends that:

- NHS Trust Chief Executives ensure workforce plans are developed for their organisation.
- Health Authority Chief Executives are accountable for preparing workforce plans to support local HImPs.
- Workforce Development Confederations are established to bring together NHS and other employers of healthcare staff to:
 - ensure coherence across their area and that all staffing requirements are identified;
 - provide information to support central planning for basic professional training;
 - contract for NHS-funded education;
 - provide a focus for developing local HR strategies where appropriate.

These would replace current education consortia and take over relevant functions from Local Medical Workforce Advisory Groups.

- The establishment of sub-groups of the National Workforce Development Board to look across the board at future undergraduate and postgraduate training requirements in the light of information drawn from Confederations and Care Group Workforce Development Boards.
- NHS Executive Regional Offices to have a strengthened performance management role to ensure the delivery of local and confederation plans.
- The appointment of Directors of Workforce Development in each Regional Office, to whom postgraduate deans and others would report.
- A comprehensive review of information requirements to support workforce planning.

Improved training, education and regulation

The review recognises the need to build on, and develop, partnership working with those providing training and education for the NHS workforce and with the relevant regulatory bodies. Education providers should be fully involved in developing workforce plans in local health economies, contributing their knowledge and expertise. It is also important that the NHS works with higher education providers and regulatory bodies to improve the flexibility of basic and post-basic training programmes, facilitating career shifts during and after training. Some of the more detailed proposals include:

- The development of training and education arrangements for staff which are genuinely multi-professional and provide greater scope for switching training paths without staff having to start their training afresh.
- Building on the changes in the nursing strategy *Making a Difference* to develop wider entry routes into nurse and other professional training, and working with higher education providers to design appropriate training for new types of healthcare worker.

- Addressing contract price variations for NHS-funded education and developing longer-term contracts with education providers.
- Placing a clear responsibility on individual employers and Workforce Development Confederations, to establish good quality clinical placements, and to establish Specialist Registrar posts, supported by more flexible funding arrangements for such posts.
- Ensuring that accreditation is not withdrawn from medical and dental training posts without a proper discussion of service and other related issues.
- A new relationship between the NHS and clinical staff whose education it funds under which if staff commit to working to the NHS for a fixed period the NHS would commit to employing them for that time subject to satisfactory performance.
- Reviewing the private sector's contribution to education and training.

Staff numbers and career pathways

The review recognises that England has fewer doctors per head than many other Western countries. Although staff numbers are not the only factor here – there are issues about how efficiently and effectively staff work – there is a need for more staff. While not centrally concerned with workforce numbers the report recommends a review of the longer-term requirements for all professional staff.

The report recognises the need for clear and flexible career structures and pathways for staff, which reflect the changing ways in which staff, will wish, and need, to work in future. Much work has already been done, or is in hand, in this area, particularly for nurses, therapists and scientists but the report believes more needs to be done. In the medical and dental fields it believes there will be an increasing need for hospital services to be delivered by fully trained doctors and dentists. It proposes that:

- The number of fully trained doctors and dentists will need to increase but this will need to be accompanied by changes in the way in which they work. This could be achieved through changes to consultant contracts and job plans but serious consideration should also be given to establishing a specialist grade which would be staffed by fully trained doctors who would work alongside, but not under the clinical supervision of, consultants and be appropriately remunerated.
- Steps should be taken to provide a proper career structure for staff employed as non-consultant career grades (eg. staff grades, associate specialists and other Trust-specific grades), which will see them providing a valuable and valued role within the hospital and community health services.
- The SHO grade should be reformed with the aim of providing better and broader educational experience and a reduction in inappropriate workload.
- Improved career counselling and support arrangements should be developed for doctors in training and other staff, particularly in the early stages of their careers.
- Action should be taken to enable Specialist Registrars and consultants to retrain in another specialty if they wish to without requiring them to start from scratch.
- There should be a fundamental review of the primary care workforce.

Implementation

The review recommends that a properly resourced implementation team be put in place to ensure delivery of the changes it recommends.

What are we trying to achieve?

1.1 A modern NHS is one which delivers care to patients in a way which is sensitive to their needs and expectations. It is a service which offers advice and support to help people manage their own care, quick and easy access to services when this is needed, high quality clinical care, seamless care between primary, secondary and tertiary settings and care which is integrated with other services, for example social services. To deliver this the NHS depends on its staff. It needs a workforce which has the skills and flexibility to deliver the right care at the right time to those who need it – a workforce which has the right number of staff deployed in the right places and working to the maximum of their ability.

1.2 This report is about how we make sure we have the staff we need to deliver this new kind of service. It is about the systems for deciding how many staff we will need, and ensuring that sufficient are trained. It is about how those staff should work together to deliver services, and how we can design a more flexible system that will help us with the inevitable peaks and troughs in the supply and demand for different skills. It is about how staff who would like to stay in the same field of health care, but change roles, can avoid having to re-train from scratch for the new role and so make the transfer rather than leaving health care altogether. It is also about how we keep committed people in the NHS even when they need to adjust their skills base and work roles, and how the NHS gets a decent return on its investment in the training of health care professionals of all kinds.

1.3 It is about looking at the workforce in a different way, as teams of people rather than as different professional tribes. For too long we have planned and trained staff in a uni-professional/uni-disciplinary way without a clear and comprehensive look at the future. This means that some of our best plans for service improvements are thwarted because we can't recruit and deploy staff to provide the service we want. For example, to achieve what we want in mental health services requires more doctors, nurses, social workers and therapists but it also means we need them to work in different ways. Our complex planning, training, and funding mechanisms lead to gaps in areas where the people of our country need expert help. Any mental health user knows that psychiatric nurses and social workers must work closely together, but rigid regulatory frameworks make this difficult, and organisational barriers get in the way of good care. The illustration below shows how services too often operate now and how we believe they should work in the future.

Present position

Patient A is a teenager with an eating disorder. He goes to his GP whose lack of expertise and pressure of work means he immediately refers to a Community Psychiatric Nurse (CPN) who has not had specialist child and adolescent training. The GP recognises that family work needs to be undertaken to enable him best to support Patient A. Social services are over stretched and unable to allocate resources. The family is unable to deal with increasing stress. The teenager is gradually becoming seriously ill. 7 day support would potentially enable Patient A to be cared for in the community but is not available. His condition deteriorates and he has to be admitted as an emergency to an adult in-patient unit. This causes distress for both Patient A and his family. Progress at school is stalled and he misses his school friends.

Following discharge a short letter is sent to the GP but there is no co-ordinated programme of rehabilitative care involving the GP, health visitor and social worker.

Issues

Absence of protocols and clinical guidance for the less common mental health disorders in childhood and adolescence for the primary care team.

The CPN and other health professionals may only have had minimal access to specialist training programmes and few will have received an advanced practice/Master's level education.

There is little supervision and variable access to specialist advice which would enable the practitioner to manage, independently and consistently, the needs and problems of the patient and his family.

There is patchy liaison with, and reciprocal involvement of, social services in responding to the health needs of a young person with a mental illness.

The current models of working are rigid, usually weekdays during office hours, which constrains the potential flexibility of the practitioner to respond to individual and family needs in the community. Access to adolescent in-patient services is not currently flexible enough to provide integrated and tailored programmes of shared care with community teams.

The concept of joint multidisciplinary/multi agency education and training is only just beginning to develop in child and adolescent services.

5 years on – The Value of Flexibility A potential model

Patient A is a teenager with an eating disorder – his mother remembers when she herself was hospitalised for such a condition, and treatment was medically driven with little patient or family input.

She takes him to the GP who looks up his PCT's protocol on eating disorder and refers him to a clinical practitioner.

Patient A's care is managed and mostly delivered by the clinical practitioner, who manages as much of Patient A's care as possible in his home, with only brief periods of in-patient care in a local community mental health facility. The clinical practitioner often sees him and his family at weekends. Patient A misses very little schooling and two years later is beginning a long-term rehabilitation programme. Continuity of care is provided throughout by the clinical practitioner with GP support.

PCT wide protocol – (in line with NSF standards and relevant NICE guidance) pools expertise for less commonly occurring disorders allowing the PCT to provide a quality service for GPs to access

Clinical Practitioner – trained as a mental health nurse, took a Masters degree in mental health, and the two “bolt-on” modules which give her approved training in psychology and nutritional science to enable her to manage eating disorder cases independently.

She works closely with her social services counterpart in cases where there is significant family disruption.

The clinical practitioner is happy to work at weekends occasionally as she manages her own time within an overall monthly contract. This enables her to use time during the week to shop and volunteer at her children's school.

She attends regular training sessions with others involved in care for eating disorders led by a local specialist psychiatrist.

1.4 Traditional demarcations between staff have held services back. The provision of health services should depend on the skills of staff, not their job title. At the simplest of levels, if nurses are allowed to insert intravenous lines and administer chemotherapy to breast cancer patients, shouldn't they also be able to follow up those women's after care therapy, ordering appropriate x-rays and other investigations? By liberating the skills of the whole NHS workforce patients will get more flexible, faster and effective care.

1.5 We heard of a number of excellent developments in practice. For example:

- in some places nurses are able to perform biopsies and clinical examinations where women are referred to their breast clinic. A specialist nurse provides support for the patient while the doctor explains the diagnosis and supports her when she is ready to consider the treatment options available to her. She also continues to support the patient pre- and post-operatively. Other nurses administer chemotherapy and palliative care where necessary but it is the specialist cancer nurse who is with the woman all through her treatment, providing the continuity and support she needs.
- in another area a network of specialist GPs have set themselves up to provide a variety of services to patients which would previously been done outside the primary care setting. Several of them are accredited to provide endoscopy, cystoscopy, and flexible sigmoidoscopy. They underwent a rigorous training programme and performed many procedures under supervision before they worked alone.
- elsewhere there is work going on to develop the roles of physiotherapists and radiographers to undertake first line treatment and rehabilitation work in palliative care.

These approaches need to be built on and made more common.

1.6 As these examples make clear, above all this report is about making the needs of patients central to workforce development. As the Secretary of State said in a speech last November:

- We want the whole patient experience to be transformed. Our vision is of an NHS where services are shaped around the convenience of patients.

During the review we met patients and their representatives. They said that patients are looking for staff to spend time with them, for clinical expertise and for continuity of care. They want to be involved in decisions about their health care but to do this they rely on information provided by staff who have listened to them, got to know them and applied expert consideration to their health care needs.

1.7 This report is about how we can change the worst features of our current workforce planning and development systems while building on what is good. It is about how we can start to transform the healthcare workforce to deliver the services the public wants in the 21st century.

What do we mean by workforce planning?

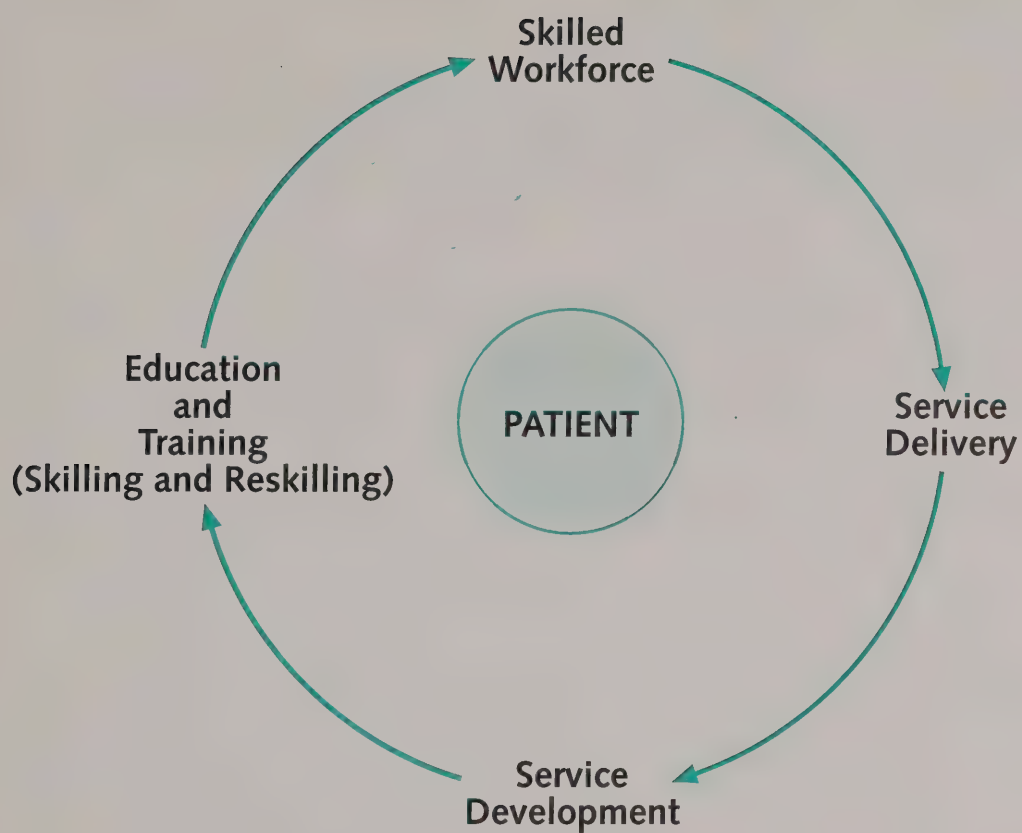
2.1 Workforce planning means many things to many people. At its simplest workforce planning is about trying to predict the future demand for different types of staff and seeking to match this with supply. But workforce planning does not take place in a vacuum. **In the case of healthcare its fundamental purpose is to ensure that there are sufficient staff available with the right skills to deliver high quality care to patients.** Workforce planning, in other words, is an activity done to support patient care and not for its own sake. This principle was accepted by those we talked to and it is important that it is turned into a reality in future.

2.2 Doing so will, however, require a more holistic approach to workforce planning than has always been the case hitherto. The range of HR policies, including education, training, pay, skill mix, recruitment and retention, and career structure issues as well as technical supply and demand modelling need to be brought together in a process of **workforce development** of which **workforce planning** as traditionally defined is only a part, albeit an important part. It will also require a fundamental cultural change to put the patient, as the consumer of services, rather than staff as the providers of services, at the heart of workforce planning.

2.3 This has a number of implications. In particular:

- Workforce development has to start from the definition of the **services and potential services** the public need.
- This in turn needs to drive debate on the **skills and competencies** required to deliver these services and thus the **numbers and types** of staff required. In assessing staffing requirements it will be increasingly important to recognise that **it is the skills and knowledge which staff can bring to patient care which are important rather than simply their professional background.** It will be important also to recognise that staff are not involved only in patient care but in a range of other related work – teaching, clinical governance, management, further training and development – which take time and require specific skills.
- **Education and training need to be responsive to the skills and competencies required for healthcare delivery.** It is critically important that the needs of patients for care, and of the NHS and others as providers of care, drive the education and training agenda.
- Finally the continuing process of service development will highlight changes in clinical practice which will need to be fed systematically into thinking about service provision and into training and education. **It will be important that, in thinking about the nature of the workforce required in future, planners do not simply fight yesterday's battles.**

2.4 The diagram below sets out how we see the relationship between the patient and the workforce of the future – a relationship which is central to the Government's agenda for modernising the NHS, improving the quality of care and making services more sensitive to the needs of patients rather than those who provide care. We believe that a similar modernisation is required in the way in which all those involved in workforce development go about their business.



2.5 If this is how we believe workforce development should be operating, how does the current system measure up?

Current workforce planning arrangements

3.1 In looking at **current** workforce planning arrangements there are separate systems for planning the medical and dental workforce, for other clinical staff and for non-professional staff.

Medical and dental workforce planning

3.2 Planning for the future medical and dental workforce is complicated by three factors:

- The length of time which training takes (some 15 years from entering medical school to becoming a consultant);
- The range of different specialties for which staff are being trained;
- The need to take account of the different needs of specialist practice and general practice.

For that reason a substantial amount of time and effort is put into workforce planning for this group at national as well as local level.

3.3 First, long-term decisions need to be made on the number of students who should be admitted to medical and dental schools to support the growth and development of the workforce in future. For medical students, these decisions are made by Government on the advice of the Medical Workforce Standing Advisory Committee (MWSAC). In the light of its last report the number of UK medical undergraduates is currently being increased by 1000 to around 6000 by 2005. In carrying out its work MWSAC takes account of a wide range of factors including the resources likely to be available for healthcare, the extent to which the health service should look to be self-reliant as opposed to using overseas doctors, and assumptions about the ways in which healthcare will develop. Once the long-term targets for student intakes have been decided by Ministers in the four UK countries, decisions on the annual targets for the distribution of medical school places in England are made by the Higher Education Funding Council for England (HEFCE) in consultation with the NHS Executive. The content of training is set by the General Medical Council (GMC) and the universities. Funding through the Service Increment for Teaching (SIFT) is provided to support the additional costs to the NHS of clinical teaching of undergraduate medical and dental students and amounted to £494m in 1999–2000.

3.4 On graduation, medical students apply for posts as Pre-Registration House Officers (PRHOs). Sufficient posts are made available both nationally and for each postgraduate deanery for the output from medical schools and for those graduating outside the UK who are eligible for registration to undertake PRHO training and who wish to work here. Regional postgraduate deans are responsible for identifying and approving posts. Funding is available for 100% of the basic salary costs of PRHOs from the Medical and Dental Education Levy (MADEL) which in 1999–2000 totalled – for all purposes – some £660m.

3.5 At Senior House Officer (SHO) level the number of posts is agreed at regional level by postgraduate deans taking account both of service and of educational needs. Deans may only establish new posts exceptionally in specialties where there are insufficient basic specialist training opportunities to feed the Specialist Registrar grade.

Again funding support is available from MADEL but at 50% of basic salary costs. SHO posts need educational approval from the relevant medical Royal College and the content of training is set by the Specialist Training Authority of the medical Royal Colleges (STA). The medical Royal Colleges administer the examinations for Membership and Fellowship required for trainees to progress.

3.6 All medical graduates need to go through PRHO and SHO training but above that level different training paths are followed for general and specialist practice. For general practice there is a period of GP registrar training which lasts 1 year after SHO training. The content of training is set by the Joint Committee on Post Graduate Training in General Practice (JCPTGP), MADEL funding will be available from April 2000 to support the costs of GP registrars.

3.7 Once qualified, GPs can practice as GP principals on a Health Authority list or in a salaried capacity working to a principal. They can also work in a personal medical services pilot providing equivalent medical services. The distribution of GP principals is controlled by the Medical Practices Committee (MPC) which has the statutory responsibility to ensure an equitable geographical spread of GP principals.

3.8 In the case of general dental practice a dentist can set up in private practice immediately on completion of undergraduate training but has to undertake 1 year of vocational training to work as a principal in the NHS. There is no equivalent of the MPC to control distribution.

3.9 For specialist practice there is a period of training as a Specialist Registrar. Decisions on the number of GP registrar posts required to meet planned expansion (currently 1% a year) and on the number of Specialist Registrar posts in each of 64 medical and dental specialties needed to meet future consultant requirements are made annually by Ministers on the advice of the Specialty Workforce Advisory Group (SWAG). This is a sub-group of the Advisory Group on Medical Education, Training and Staffing (AGMETS) and has members drawn from the main medical representative bodies, academia, the Academy of medical Royal Colleges and contains only four NHS managers. Its recommendations take account of advice from medical Royal Colleges, specialist societies, postgraduate deans, NHS Trusts and Health Authorities as well as information on projected retirements and resignations in each specialty.

3.10 The task of SWAG in the specialist sector is particularly difficult given the number of specialties, the length of higher specialist training (6 years on average) and the uncertainties over NHS requirements in the long term. While SWAG has made real efforts to involve the NHS more effectively in its work it has not always received the level of information which it needs to do its job. Significant year on year changes in the number of training places are undesirable given these uncertainties and the need not to disrupt the service provision from specialist trainees.

3.11 Postgraduate deans work with NHS Trusts in their area to establish training posts, which require educational approval from the STA. Most Specialist Registrar posts receive 50% funding support from MADEL. SWAG operates using a system of national training numbers (NTNs) and allocates sufficient training numbers in each specialty to provide for its estimate of the number of trainees required to meet future consultant demand. However not all training numbers are taken up in each specialty – either because of a lack of trainees or because of an unwillingness on the part of the NHS to establish training posts – and the number of trainees in training is usually less than the number of NTNs, an issue which further complicates SWAG's planning work.

3.12 Entry to specialist training leading to a Certificate of Completion of Specialist Training (CCST) is on the basis of competitive application and not all SHOs who wish to enter training in a particular specialty will be able to do so. They may try for training in another specialty, remain inappropriately in SHO posts, or take up employment as a staff grade or other non-consultant career grade providing service support only.

3.13 On completion of specialist training doctors and dentists obtain a CCST, a qualification which is recognised across the European Economic Area (EEA). They are eligible for entry on the Specialist Registers of

the General Medical Council (GMC) or General Dental Council (GDC). Once registered they are eligible to apply for advertised consultant posts. Job descriptions for consultant posts have to be approved by the relevant medical Royal College to ensure they provide an appropriate balance of service and other commitments. Normally Specialist Registrars may only remain in post for 6 months after completion of training but in exceptional circumstances this can be extended to 18 months. After that they must move on – into a consultant or other post.

3.14 While the majority of trainees will move into hospital or community medicine others will move into academic medicine and SWAG takes account of this, and increasingly of the needs of other employers such as the armed forces, in its work.

3.15 It will be clear from this brief description (which is set out in diagrammatic form at Appendix A) that medical workforce planning is predominantly top-down. However it is not entirely so. At a local level NHS Trusts need routinely to review the medical workforce they currently have and will require in future, including replacement, retention and restructuring, and should feed the results of this thinking into the deliberations of SWAG and other national groups. In addition Local Medical Workforce Advisory Groups (LMWAGs), which consist of representatives of NHS management and the medical profession, and generally operate at regional level, may comment and advise on individual NHS Trusts' current and planned staffing arrangements in terms of grade-mix and quality. LMWAGs may also advise NHS Executive Regional Offices, education consortia, Health Authorities and postgraduate deans, particularly if they have concerns, for example, over the balance between consultant and other grades.

3.16 Education consortia (whose role in respect of workforce planning for clinical staff other than doctors and dentists is set out below) also have the function, working through Regional Education and Development Groups (REDGs), of providing advice on the number and types of doctors needed and on the local arrangements for post graduate medical and dental education. In practice education consortia have not regarded medical and dental workforce issues as at the heart of their work given the other arrangements which are in place for planning for these staff.

Workforce planning for other clinical staff

3.17 The arrangements for workforce planning for other clinical staff vary significantly from those for medical and dental staff. This reflects the significantly shorter training times for staff in these groups, the very different education and training arrangements, and the fact that the NHS is much less of a monopoly employer for these staff than for medical and dental staff.

3.18 The focus of planning for these groups, which include:

- Nurses, midwives and health visitors;
- Professions Allied to Medicine (for example physiotherapists, occupational therapists, chiropodists, speech and language therapists, dieticians and radiographers);
- Professions complementary to dentistry (including dental hygienists, dental therapists, dental technicians and dental nurses);
- Scientific and professional staff (including pharmacists, clinical psychologists, and clinical scientists such as biochemists, non-medical microbiologists and medical physicists);

is at NHS Trust, and other local employer, level.

3.19 NHS Trusts are expected to produce workforce plans covering a 5 year timeframe, taking account of expected retirements and other wastage, planned service changes and skill-mix changes. NHS Trust plans are submitted to local education consortia which have the functions of:

- Aggregating NHS Trust workforce plans with those from other employers of healthcare professionals (primarily social services and the private and voluntary healthcare sector) in the area to assess the number of training places, both at pre-registration and post-registration level, which need to be commissioned.
- Commissioning education from education providers – local universities for the most part, but also Further Education institutions.

Education consortia are also expected to take account of the requirements of primary care and of other, non-NHS, employers. In addition to this core work some education consortia have developed their role and taken forward work on recruitment and retention across their area.

3.20 NHS Executive Regional Offices and their REDGs are responsible for validating education consortia plans and submitting them to NHS Executive HQ which may modify the aggregate bottom-up figures to take account of national development priorities, particularly for smaller staff groups. At the end of this process decisions are made on the overall number of places to be commissioned and the numbers to be commissioned within each region and by each education consortium. These will be based on, but not necessarily identical to, the initial assessment by the education consortium. Education consortia are then responsible for purchasing the agreed number of places. For smaller professions, lead education consortia undertake the planning and commissioning process for all education consortia in a region in order to deliver benefits of scale and avoid fragmentation.

3.21 Undergraduate training places and post-registration training and education, including some continuing professional development and other development work, are funded from the Non-Medical Education and Training Levy (NMET) which amounted to some £907m in 1999–2000. NHS Executive Regional Offices are responsible for performance managing the education consortia. The NMET levy does not cover undergraduate training for all non-medical professions – for example undergraduate pharmacy education is funded through HEFCE and education consortia are involved only in funding pre-registration posts in hospitals.

3.22 Local workforce planning alone would be impractical for a number of small professions – for example dental support staff, psychotherapists and scientists and technicians – and a number of national workforce advisory groups have been established to provide a national focus and strategic overview for these professions. A time-limited group has also been established to ensure the smooth transition from DfEE to DH for responsibility for funding education and training for chiropodists/podiatrists, dieticians, speech and language therapists, orthotists and prosthetists. These groups contain a mix of Departmental and NHS staff with experience of the groups concerned, workforce planning issues and education and training. For some of these groups there is national purchasing of education and training.

3.23 The curricula for pre- and post-registration training programmes for these staff are set by the universities and other institutions within frameworks provided by the relevant statutory and professional bodies. For example guidelines for pre-registration nursing curricula are issued by the English National Board (ENB). Training programmes and the institutions that provide them, particularly at pre-registration level, are normally approved (quality-assured) by the relevant statutory professional and educational bodies to ensure that students meet both academic, professional and, in the case of pre-registration education, registration requirements. Education consortia also have a keen interest in the quality of education which they fund. The NHS Executive is developing proposals to streamline the quality assurance process from September 2001.

3.24 These arrangements are set out in diagrammatic form at Appendix B. While different in kind, the requirements for planning this workforce are in many ways as complex and demanding as for planning the medical workforce. The process is, however, much more “bottom-up” than is the case with medical workforce planning.

Workforce Planning for Managerial and other Staff

3.25 There is little co-ordinated planning for these groups as the NHS and other healthcare providers are usually looking for people with generic skills. There are however some excellent examples of training schemes for managers and other staff, for example finance staff, aimed at developing skills and retaining staff in the NHS workforce. There is a national management training scheme – a postgraduate scheme to attract high calibre potential top managers – but this is not designed to fill workforce needs, and most managers are “home grown” i.e. trained on the job. There are regional and local training schemes, again not planned against workforce targets, but seen as delivering just part of the necessary staffing. Other staff are not planned collectively at all.

Where do the problems lie?

4.1 It will be clear from this brief description that the current workforce planning and development arrangements do not align fully with either the general principles set out by the Government in their response to the Health Committee or with our desire to see patients and their needs at the centre of workforce planning and development. In particular the current arrangements are not:

- Built around service needs and the skills required to deliver them;
- Well integrated with service and financial planning;
- Holistic in their approach, looking across primary, secondary and tertiary care or across staff groups;
- Responsive to service changes and developments;
- Supportive of multi-disciplinary training, education and working.

4.2 We believe that significant changes are needed to ensure we have a workforce which will deliver the Government's modernisation agenda in terms both of service development and of clinical governance. To do this it will be necessary to tackle a wide range of issues which we have identified in our work and which are set out briefly below.

4.3 In saying this, and in making the comments below, we are conscious that healthcare workforce planning is an exceptionally complex task. It is complex because of the number of professional groups involved; the often long lead-times for training which make it difficult to anticipate service demands for staff; the role of the NHS as a dominant, and for some groups almost a monopoly, employer, which gives it a moral responsibility towards healthcare professionals which is unusual for an employer; the pace of change in the NHS; and the number of separate NHS and other organisations whose requirements for staff need to be taken into account. While attention is often drawn to the failures of healthcare workforce planning it is important to recognise that failures will happen in a complex system. In our view **however good the analytical and decision making systems are, there will always be mismatches between the supply of and demand for groups of professional healthcare staff.** The aim should be to minimise those mismatches and have in place robust systems which can cope with them, including sufficient flexibility in the workforce and work-roles to make changes quickly.

4.4 We have identified four main areas of concern with the current arrangements:

- **Fragmentation of planning and lack of technical skills.**
- **Lack of management ownership.**
- **Training and education weaknesses.**
- **Career structure and workforce numbers issues.**

Fragmentation of planning and lack of technical skills

4.5 At present our workforce planning and development systems are fragmented and poorly integrated in a range of ways. First, and most fundamentally, **greater attention needs to be paid to making proper links between service, finance and workforce planning both at local and national level**. While Health Improvement Programmes (HIMPs) should be backed by workforce plans, and the guidance *Modernising Health and Social Services: Developing the Workforce* sets out the key priorities for workforce planning, it was not always evident that this process was properly integrated. Similarly it was not evident that the development of national service plans – for example through National Service Frameworks – had been fully informed by thinking on workforce issues.

4.6 Furthermore, **the approaches to workforce planning for doctors and dentists and for other clinical staff are not aligned**. It is difficult to plan creatively, or to develop innovative staffing solutions, in circumstances where planning systems, cycles and timeframes are out of step. Very different approaches to planning also make it difficult to look properly across primary and secondary care settings. People's need for care is not neatly divided in this way and services and staff should not be either. The fragmented and uniprofessional approach to workforce planning was as much a feature at regional and national level as at local level despite recent attempts to improve integration.

4.7 **There is also insufficient recognition of the role of non-NHS employers in workforce planning and development**. In particular the development of new partnership arrangements between health and social care will make it critically important that there is genuine joint working between employers to identify how best to provide care to individuals. It will no longer be possible to try to plan the NHS or social care workforces in isolation. We were concerned that the impact of these changes on workforce development had barely been considered. Furthermore there is a need systematically to engage the private, independent and voluntary sector in thinking about workforce issues as they are significant employers of nursing and other staff trained by the NHS. We recognise the difficulty of achieving this given the very diverse nature of this sector, but a failure to do so may have serious consequences for the NHS.

4.8 This fragmentation is compounded by the **separation of funding streams. The main levies (SIFT, MADEL, and NMET) and other sources of funding from NHS Trusts or other bodies to support workforce development in its broadest sense, including library and IT provision, are managed as separate pockets of money**. This inhibits the scope for supporting the delivery of inter-disciplinary education and the development of creative workforce solutions, and creates tension due to the different levels of subsidy for different staff groups at basic and post-basic levels. This is exacerbated by the fact that a number of staff groups do not receive levy funding for training and education. At the margin this may affect decisions on the choice of staff to perform particular functions.

4.9 The SIFT and MADEL levies form significant elements in the funding streams of NHS Trusts and their financial viability. In any reform of the funding of education and training it will be important to assess the effect of the proposals on the financial stability of NHS Trusts and to ensure that any impacts on their costs or activity are neutralised.

4.10 **There are major weaknesses in the information base used for workforce planning** on both the supply and the demand side. Concerns about the adequacy, accuracy and timeliness of national data on staff had led to the development of separate and often inconsistent databases. This was particularly prevalent in the medical world where discussions on Specialist Registrar posts could be “informed” by data from three sources – the Department of Health, postgraduate deans and medical Royal Colleges. We were struck in this context by the paucity of information on other staff involved in providing care for different groups of patients – eg those with cancer. And on the demand side the lack of good information from NHS Trusts, general practice and other providers of care made it difficult to be clear what sort of workforce was required, in what numbers and for what purposes.

4.11 Finally it is important to mention three other areas where the lack of an integrated approach has costs. The first is **the lack of a consistent effort to build research and development findings into thinking about the future workforce**. New medical techniques, particularly developing drug therapies, will change – both upwards and downwards – the future requirement for staff. We were also conscious of the potential impact of genetic research on healthcare provision. Of course it is important to take a realistic approach to assessing the impact of changing technologies but they should not be ignored in the planning process, especially as the length of time from development of new techniques to their application in routine practice is often much less than the time it takes to train professional staff.

4.12 The second is **the lack of a consistent focus on skill-mix issues**. There is a range of individual initiatives to use staff more flexibly and to develop service based approaches to determining workforce requirements, using required competencies rather than professional roles to allocate tasks, as exemplified by at least some of the proposals for nurse consultants and by the Future Healthcare Workforce project. But there seemed to be **no national drive to share learning and good practice or to support NHS Trusts seeking to develop innovative approaches**. Furthermore there was often perceived resistance to skill-mix changes, both among clinical middle managers who were uneasy about staff who followed varied career paths and among staff concerned about “dumping” of tasks. **This needs to change if the NHS is to deliver the sort of service which Ministers want to see**. In particular developing new skills, taking on new roles and working outside traditional boundaries needs to be encouraged and rewarded rather than regarded as inappropriate. This will require changes in education and training, in regulation and in employment practices, and a willingness to embrace change among all bodies including staff representatives.

4.13 The third is **a shortage of technical planning skills** in the NHS both to undertake workforce planning as currently defined and to take on the more complex and integrated approach we envisage. In particular we expect there will be a greater need to plan for a range of different scenarios and to plan over longer time horizons. This skills deficit will need to be addressed.

4.14 We were also very aware of the difficulty of deploying trained staff more flexibly – the culture of specialisation, which had benefits in terms of quality of care militated against this. We were particularly concerned about **the perceived pressure on young professionals to settle on their careers at an early stage in their training**, often without wide exposure to other options, thus limiting their future career choices. At the other end of the career ladder we were aware of **the potential impact of specialisation on the ability to run effective services e.g. to establish appropriate surgical “on-take” arrangements**. While increasing specialisation is right where evidence points to improved outcomes, there is a danger that it might be advocated for its own sake.

4.15 **There is also insufficient support for staff who wish to change roles during a health-care career** – the portfolio career will affect the NHS as elsewhere. In the future many individuals will want to work flexibly as they seek to balance work with leisure, further training and family commitments. Staff trained and prepared for flexible working will enable better workforce planning for the NHS. We were concerned that **the NHS pension scheme was seen by some to hinder creative work arrangements, particularly towards the end of a career**.

Lack of management ownership

4.16 We were concerned about the **lack of proper engagement by many senior NHS managers and policy makers in workforce issues** in a way which would be inconceivable in relation, for example, to financial issues. This was particularly evident in Health Authorities but was not uncommon in NHS Trusts, though to be fair the system has not always made it easy for managers to engage fully. There were no apparent incentives to do workforce planning and development well – and few sanctions when it was done badly. We were also conscious that for many people workforce planning and development is about little more than education/training and number crunching. It is important to stress that many other HR and management policies have an impact on the

supply of staff. These include pay policies; policy changes which affect motivation and hence retention and retirement rates; recruitment from minorities and older groups; and organisation cultures at a national and local level. Scare stories and organisation myths can lead to poor planning and either over-provision or shortages. Both at local and national level, the impact of these issues on the supply of skilled staff should be considered.

4.17 There were also very different levels of **NHS management input to the planning process nationally**. While the needs of the NHS were the prime drivers in planning the workforce for most clinical staff groups this was not the case for the medical workforce, where the needs of the medical profession were perceived to be dominant. This was reflected in the membership of groups such as AGMETS and SWAG and the weak input from NHS Trusts to medical workforce planning at national level.

4.18 Moreover, **while many organisations and individuals are involved in workforce planning at present there is not always clarity about their role, responsibilities and accountabilities**. Planning systems, particularly in the medical and dental field, are complex – “Byzantine” and “labyrinthine” were among the kinder descriptions used – and baffling to the outsider, dealing in currencies (eg National Training Numbers) which do not relate easily to the real world. The landscape of medical workforce planning is littered with advisory groups which themselves frequently take advice from other bodies whose accountability for the results of their advice is unclear. In relation to other clinical staff there is much apparent “second-guessing” of the advice of education consortia which potentially disempowers them, and wastes their time. And as we have noted earlier there is a lack of technical planning skills. **Coupled with this is a lack of clear performance management of NHS Trust and Health Authority workforce plans.**

4.19 In addition, **education consortia, which are the linch-pins of workforce planning and commissioning for clinical staff other than doctors and dentists, vary significantly in their effectiveness, skills and ability**. The best have fully engaged all the key stakeholders and have the capacity and capability to take on a wider role but others struggle to do more than the basic job, failing to use the powers they have effectively. They have taken on workforce planning as an afterthought in the absence of good information from local NHS Trusts and Health Authorities to guide their education and training role, and some lack the technical skills to do this well. Furthermore, education consortia often operate in different groupings to natural planning economies for either labour or health, reflecting the pattern of education provision. There are real issues about the investment in education consortia development and skills, about the deployment of the available skilled resource, and about whether the time they have available is best used in the current arrangements. Frustration was expressed about time consuming local plans being over-ridden by national imperatives.

Training and education weaknesses

4.20 **There is a need to develop and improve the relationship between the NHS and providers of education and training**, particularly in relation to those clinical staff, including nurses, whose education is funded by the NHS but provided by Higher Education Institutions. While we saw much of benefit in the current arrangements we identified a number of concerns:

- **A disjunction between the needs of the NHS and the desires of education providers.** This was sometimes referred to, pejoratively, as an over-academicisation of basic training with a selection process which emphasised academic ability over caring skills and an educational regime which left staff insufficiently prepared for their first few months of work. Similar concerns were raised about the impact of the Calman reforms on specialist medical training, with suggestions that they left doctors unready to take on the consultant role. Others complained that gaps in training syllabuses affected future recruitment in specialist areas such as theatre nursing.

- **Different incentives operate in the higher education sector, in particular the high value placed on research compared to teaching as an indicator of success.** This in turn affects future funding. Vocational courses need a heavier emphasis on teaching.
- **Some higher education staff are perceived to be out of touch with modern service needs.** Since teachers operate as role models and have a major impact on attitudes to work and choice of future specialisation, **the quality of teachers for future NHS staff is very important.** Many people talked to us about the importance of planning adequately for the academic workforce and drew attention to **problems in recruiting and retaining academic staff.** We were particularly made aware of long-standing concerns about pressures on academic medicine and of some of the difficulties in working across healthcare and higher education. With increasing numbers of medical students and other demands it is important that this is not neglected.
- In addition **education providers argued that short-term contracts for educational programmes made it hard for them to recruit good quality staff,** due to employment insecurity, although others told us that the NHS pays a premium to compensate for the fixed-term nature of training contracts. This short-termism, and the lack of flexibility in programmes, are attributed to NMET constraints. We noted, however, that there are wide variations in the price paid for similar training programmes, suggesting the variation is due to more than local cost differentials, probably to bargaining power.
- **A loss of links between students – particularly student nurses – and their “home” hospital,** making it more difficult to recruit and retain staff. This was recognised in the nursing strategy *Making a Difference* published in July 1999 and education consortia are taking action on this issue, building on initiatives that are already being taken in some places.
- **A lack of responsiveness to the changing needs both of the NHS, for example in curriculum development and developing training programmes for new types of staff, and of individuals, who might wish to change training courses but are unable to gain credit for existing skills, knowledge and experience.** In turn, professional and statutory regulatory bodies are perceived by the higher education sector to take decisions for one part of the workforce without adequately considering the implications for other groups. There are some good examples of integrated training of NHS professionals, and even joint qualifications such as that in learning disabilities nursing and social work pioneered by the ENB, but these are few and far between. More work is needed to build on these pilots to ensure that joint training encourages good teamworking, flexible roles and careers, whilst recognising the distinct qualities of different professional groups. **However, at present, innovative educators complain that there is little point in developing new breeds of professionals if the NHS is not ready for them. Innovative NHS Trusts complain that they have to retrain new staff to work in more flexible and integrated ways.**
- **The failure of the NHS always to play its part by providing adequate numbers of clinical placements for trainees, whether as part of basic training or for specialist training, including Specialist Registrar training posts in some specialties.** This meant that we were under-training compared with the plans set out by SWAG, and that training opportunities in other professions could be restricted.
- **A perceived dominance of professional interest groups in determining the content and delivery of training.** There were concerns about the role of the medical Royal Colleges in accrediting training and, more importantly, seeking to remove accreditation without regard to the impact on service provision. Professional leaders were also seen by those responsible for delivering the service as having more influence with decision-makers than service managers.

Fundamentally there needs to be a proper balance to ensure both that service demands do not leave trainees with insufficient time for training and that changes in training arrangements are made in consultation with service providers so that the impact on service delivery is fully understood. It is important that training and education needs are not seen to take priority over service requirements.

Career structure and workforce numbers issues

4.21 Finally there is a **perceived lack of coherence on workforce issues across the NHS Executive and DH, with people talking to us of a policy vacuum**. This is most noticeable in the medical area but applies across the board, and a number of those to whom we spoke made the point that improving and developing workforce planning depended crucially on knowing what sort of workforce we are planning for. In particular doctors were uncertain whether, in the specialist medical service, the Government and the NHS were looking for a **consultant-led service** operating much as now or a **consultant-delivered service** in which significantly more care is delivered by fully-trained staff with support from those in training and other staff who have chosen not to progress to consultant status. They were also uneasy about the current balance between numbers in training grades and at consultant level and about the lack of any coherent structure for staff outside the recognised training and career grades. Similarly they were unclear whether the Government expected to see an increase in the number of general practitioners to respond to the increased expectations of general practice. In such situations unplanned developments, such as the recent significant expansion of non-consultant career grade doctors, take place as employers and individuals 'vote with their feet'. Well-intentioned actions to improve training or career prospects have often not been thought through in the context of the whole system, creating a worse situation for employees, and hence services, in the long run.

4.22 The answers to these questions have profound implications not just for workforce planning and development but also for the medical career structure, for the role of medical trainees, who are still expected to carry a significant service load, and for the roles of other staff. The impact on workload of initiatives such as clinical governance and the GMC's steps to ensure high quality medical practice, building on *Good Medical Practice*, are also untested.

4.23 Underlying this are **more fundamental issues about the number of doctors and other staff required and the number of doctors which should be trained in this country**. We are conscious that England has fewer doctors per head of population than many other Western countries. This reflects a long-term bias towards under-supply which is in turn the result partly of cautious assumptions about what the NHS will be able to afford, partly of a concern not to waste public money by training doctors at considerable public expense for whom there might not be jobs in the NHS in the long term, and partly of the medical profession's concern to ensure there is no medical unemployment. But this under-supply meant that the country was currently heavily reliant on doctors from overseas, particularly at SHO level. This reliance will continue for some time to come and may increase in order to deliver the requirements of the Working Time Directive.

4.24 Similarly we noted that while over the years a number of Committees, most recently MWSAC, had been concerned to take a long-term look at the future requirements for medical staff requirements, and hence at training needs, no similar work seemed to have been undertaken for other staff groups. We recognise the inherent difficulty of doing this, especially at a time when we are looking for staff to work more flexibly, **but we were concerned about the lack of a coherent picture of the numbers of clinical staff other than doctors and dentists required in the longer-term**.

4.25 We also noted a **lack of central or local attention to the skilled, but not to graduate-equivalent level, workforce**. Some of these roles have been lost, while others have developed in varying degrees locally. Some staff groups have taken collective action to develop professional self-regulation, for example paramedics, while emergent groups such as Operating Department Practitioners aspire to the same status. In some cases such aspirations have encountered resistance from the NHS and regulatory bodies. New posts are being developed at

this level, eg mammography technicians, and more attention should be paid to this level of skill as the lead time for training is much shorter, and within the control of the NHS.

4.26 Similarly there is a need to ensure best use is made of untrained and other support staff. They have a vital role to play in delivering care to patients but are too often overlooked and neglected. It is important that NHS employers look to maximise the input, and develop the skills, of **all** their staff and to look holistically at their workforce. **Failure to do so inhibits the ability of the NHS to deliver effectively.**

Conclusions

4.27 Overall **we believe that workforce planning and development is not embedded in the culture of the NHS, with too much short-term crisis handling and a lack of constant attention to the impact of many day-to day decisions on the workforce of the future.** Similarly to primary care a few years ago, it is an area of expertise not often present in top teams at Health Authorities, Regional Offices and NHS Executive HQ, and hence ignored in decision-making. When it is considered, there is too often a sense of lack of control, given the number of external players, leading to an abdication of responsibility.

4.28 **We also consider that workforce issues do not feature sufficiently in the training curricula for managers.** We believe this needs to be addressed and that managers at both operational and strategic level need proper training in workforce planning and development issues including scenario planning.

4.29 **We do not believe this position can continue.** Over the next few years workforce issues are likely to dominate the agenda as the NHS looks to deliver the ambitious policy initiatives set out by Ministers. There will be an increasing need to look for creative solutions to problems and to use the skills and abilities of the NHS workforce to their maximum. **NHS managers and their colleagues in the NHS Executive at both HQ and Regional Office need to be both aware of and on top of workforce development issues** whilst recognising that it is almost impossible to get it right all the time.

What is to be done?

5.1 We have considered carefully what needs to be done to tackle the range of issues identified in the previous chapter and to ensure an approach to workforce development which will meet the goals which Ministers have set out. In coming to our conclusions we are conscious that, in the time available to us, we have not been able to explore all aspects of the issues we have raised. We are also conscious that it would be presumptuous of us to believe that we have all the answers to questions which have in some cases been the subject of lengthy debate over many years. Our recommendations should, therefore, be seen as the start rather than the end of a process of change which needs to engage the range of stakeholders within and outside the NHS.

5.2 Within that general context, in some areas – such as planning systems and information systems – we have been able to be quite firm in what we believe needs to be done and much of the debate should be about the “how” rather than the “what” or “whether”. **In other areas – for example medical career structures – we have sought to present ideas which will need much more debate and discussion to achieve agreement on the way forward.**

5.3 It is also important to recognise that change will take time. While some of our recommendations can be taken forward quite quickly, others require cultural changes which cannot be achieved overnight. Delivering these changes will require a clear and focused implementation programme, led from, but not solely the preserve of, the NHS Executive. While much of what we have recommended is happening at present and there are many pockets of innovation and creative thinking about the whole range of workforce issues, the implementation of this report will require initiatives that ensure **whole systems change** – that is **all** parties changing at the **same** time, so that the service, educators and regulatory bodies are requiring, producing and endorsing new kinds of role and staff to fill them. This will require challenging previously held and closely guarded perceptions about roles that have led to inflexible demarcation, to the detriment of both patients and health service employees.

5.4 We see a need for change in four areas:

- **Greater integration, more flexibility.**
- **Better management ownership, clearer roles and responsibilities.**
- **Improved training, education and regulation.**
- **Staff numbers and career pathways.**

Greater integration, more flexibility

5.5 At the heart of our thinking about workforce development in future is the need for:

- **greater integration of workforce planning and development with service and financial planning and of planning between staff groups and between primary, secondary, tertiary and, in future, intermediate care.**
- **more flexible deployment of staff to maximise the use of their skills and abilities.**

5.6 To tackle the first we believe change is needed at two levels. At local level the Health Improvement Programme (HImpP) should be seen by all players in the local health economy as the key to setting the direction for local service development, and **must** be backed by comprehensive, realistic and credible workforce plans looking forward 3-5 years. This planning process must engage Health Authorities, NHS Trusts, Primary Care Groups and Trusts, as well as the full range of other primary care practitioners and non-NHS partners, particularly Local Authorities. It must take account of the plans of all local NHS players for recruiting and replacing staff, for developing and changing services, for changing skill and grade mix and for tackling shortages and retention problems. We recognise that achieving this will require much more effective medium-term service planning by NHS Trusts and others but we believe this is necessary if we are to deliver the high-quality services which Ministers want to see. **Health Authority Chief Executives should be held accountable by Regional Offices for the production and delivery of these workforce plans and for providing clear leadership in this area.**

5.7 Such plans must be developed on a multi-disciplinary basis. They should start from a clear definition of the services to be delivered, the skills required and, flowing from this, the staffing needed in different staff groups, including the need for increasing numbers of specialist staff eg ITU nurses. This may involve a range of scenarios which can be invoked depending on the supply of different staff – for example it may be possible for some tasks to be undertaken by two or three different professionals and the precise balance of staffing may need to be determined by staff availability. **We believe that it will be important to ensure that those involved in workforce planning at local level have or rapidly develop the technical skills necessary to do this effectively.** The workforce plans should, like the HImpPs themselves, look at requirements across primary, secondary and tertiary care. They should also look at the impact of workforce availability on service plans and on the future configuration of services. **The local Health Authority through the HImpP should have the responsibility for ensuring that the workforce plans match service plans and resource availability**

5.8 We believe that the current separation of funding streams for undergraduate medical education support (SIFT), postgraduate medical and dental training (MADEL) and non-medical education and training (NMET) is inimical to effective integrated workforce development. There is a need to ensure resources are used effectively to support the changes we want to see, particularly the moves towards more flexible and integrated training and education and to develop new types of worker. We are aware that Regional Offices look to use their resources in the most effective way but we believe that this is no substitute for a properly integrated approach. **We therefore recommend that the three funding streams should be merged and that Regional Directors of Workforce Development (see below) should be responsible for their effective use in delivering agreed outputs.** In doing this they should work closely with Confederations (see below) and individual employers to ensure that maximum advantage is taken of all the resources for education and training from whatever source. It will be important that the merger of the levies is done in a way which carries the support of those involved in training and education at undergraduate and postgraduate level and **there will, therefore, need to be detailed discussions on implementation of this proposal and appropriate safeguards will need to be put in place, particularly to ensure that undergraduate medical and dental education is not inadvertently harmed.** As indicated earlier levy funding does not cover the education and training of all staff groups and we are aware of the arguments for extending it to cover all scientists and technicians. **We believe there are strong arguments for an equitable approach and that the range of groups covered by levy funding should be kept under regular review.**

5.9 **At national level, workforce issues must be built into thinking about service planning and development in the same way that financial issues are currently.** In this context we welcome the establishment of the Mental Health Workforce Action Team and the increasing involvement of human resource, training and education staff in the development of new National Service Frameworks. To help ensure that this proposal becomes a reality **we recommend the establishment of a National Workforce Development Board** to be chaired by the NHS Chief Executive which would be responsible for setting the strategic direction for workforce development issues. We do not wish to prescribe its role in detail but its functions should include:

- **Reviewing the collective impact of policy developments and plans on workforce requirements.**

- **Reviewing the impact of research and development findings, NICE guidance and other evidence on workforce requirements.**
- **Commissioning work on such issues as skill-mix and changing patterns of workforce utilisation to inform local planning and development, and rolling out good practice.**
- **Identifying and ensuring action on key education and training issues, working with stakeholders such as medical Royal Colleges, professional and regulatory bodies and the planned new education and training unit in the NHS Executive.**
- **Ensuring proper co-ordination between health and social care workforce planning.**
- **Approving the proposed numbers of students entering undergraduate training where these are nationally determined.**

5.10 It should operate at a strategic level and should bring together NHS employers, who should be in the majority, non-NHS employers, the NHS Executive, professional bodies and Trade Unions. It should not need to meet frequently, perhaps two or three times a year. It should incorporate the relevant work of existing uniprofessional groups – AGMETS, SWAG, MWSAC and the National Advisory Groups for dental support staff, scientists and technicians, psychotherapists, and the new NMET professions. **In the light of our earlier comments it will be important that there is proper representation from research and development interests on this Board and its supporting groups.**

5.11 The Board should be supported by **Care Group Workforce Development Boards** covering, for example, cancer, older people, coronary heart disease, mental illness and children, which would be responsible for considering future workforce requirements in their area taking account of service developments, skill mix changes and so forth. These should be multi-disciplinary, involving those responsible for service planning and development within the NHS Executive as well as members from NHS management, who should be in the majority, other employers of healthcare professionals, professional bodies and trade unions, and patient and consumer organisations. It will be important that those taking forward policy development work in the Department of Health engage with these groups at an early stage. The precise grouping of services, and membership of the groups, needs further discussion and **we would welcome views on this.**

5.12 These groups should be responsible for:

- **Feeding into the development of National Service Frameworks and other policy developments and considering their implications for workforce.**
- **Gathering and disseminating information on skill-mix and other changes which may affect service delivery and workforce requirements.**
- **Identifying changes and developments required in education and training to deliver a workforce with the skills required to support service changes.**
- **Considering and agreeing commissioning plans for postgraduate education and training in their care group.**

5.13 To tackle the second issue we are convinced that more concerted action is needed to encourage changes to skill-mix and more flexible working. Traditional demarcation lines between professional groups and between professional and non-professional groups (eg between doctors and nurses or between nurses and health care assistants) are not conducive to delivering high-quality, patient-centred, care. The changes needed to deliver the

new, transformed, NHS which is Ministers' aim will inevitably drive change in the way staff are used and the skills they have. **But it is vital that employers and the NHS Executive are pro-active in tackling these issues.**

5.14 Action is needed on two fronts. **First, all employers need to maximise the skills of all their current staff and review the way in which jobs are designed and care delivered.** We are aware of a range of initiatives taken by NHS Trusts and other employers in this area – including the development of nurse consultant posts – but more needs to be done to drive this through the NHS and to ensure that the modernised pay systems proposed in *Agenda For Change* are used to best effect. In developing and expanding the roles of health professionals it will be important not to lose staff's professional identities but to develop additional skills which will enable them to work more flexibly and give them more transferable skills. It will be important to involve the statutory regulatory bodies in discussions about increasing the flexibility with which professional staff are used, and particularly proposals for them to work outside their normal roles, in order to avoid potential blockages to change. And it will be important to ensure that the skills and capabilities of other staff are fully used. Decisions on who can provide care should start from the patient's needs not professional background and training.

5.15 In this context we welcome the plans which are being developed to extend the scope of prescribing by nurses following the final report of the *Review of Prescribing, Supply and Administration of Medicines*. We believe that this represents a positive move which will benefit patients and the NHS, though we also recognise the importance of ensuring that this work is taken forward in a way which does not compromise patient safety.

5.16 **Second, there needs to be concerted action to take forward work to develop the roles of new types of workers. Consideration here will need to be given to those who are trained and skilled but not necessarily to graduate-equivalent level.** These staff are vital to the effective running of the NHS and can potentially relieve the pressures on other staff such as SHOs. The potential for the development of new roles has not been sufficiently explored. Action in this area should build on the thinking about a “physician's assistant” role and on the current work in hand taking forward recommendations from the reports on *The Future Healthcare Workforce*. We are concerned that there does not appear to be any strategic leadership here and **we recommend that the NHS Executive should co-ordinate and lead work in this area, drawing on experience in the NHS and among professional groups.**

Better management ownership, clearer roles and responsibilities

5.17 In addition to professional engagement, effective workforce planning and development requires clarity about responsibilities, proper management and clear systems of performance management. At present this is not happening uniformly and we set out here our views on the planning systems and arrangements which should operate in future. They are summarised in the diagram at Appendix C.

Employer level

5.18 First, we are clear that **it is the responsibility of each NHS Trust or other local employer to develop workforce plans for their organisation and to be held to account for their delivery.** They will need to consider local recruitment and retention issues, job design, skill mix, staffing changes required to deliver service change as well as related HR issues. They will need to develop their plans on a multi-professional basis centred round the services to be delivered. **This should be seen as a core role for NHS Trust and PCT/PCG Chief Executives. We would see this as reinforcing the ability of NHS Trusts to develop their workforce in innovative ways best suited to their local circumstances.**

5.19 Second, as indicated above, **we believe that Health Authorities should be responsible for ensuring the preparation of a comprehensive workforce plan to support the HImP.**

Supra-employer level

5.20 Third, while these plans should provide a major input to national workforce planning we do not believe that they are sufficient on their own. This is for two main reasons. First the NHS is not the only employer of healthcare professionals. The private and voluntary healthcare sector, local authorities and other employers (eg companies which provide occupational health services for their staff) all fish in the same pool of trained staff. Second the time horizon for local planning is necessarily limited compared with, for example, the time required to train doctors. We therefore believe that there is a need for an organisational structure above local health economies but below national level.

5.21 **We therefore recommend the establishment of local Workforce Development Confederations** to bring together NHS and other employers:

- **To review and aggregate the plans of the range of local employers in order to develop an overall confederation plan.** For this to work effectively will require non-NHS employers to provide workforce plans to the same standard as NHS employers.
- **To submit information to inform central planning for basic professional training.** The current arrangements under which the national training requirement is built up from local plans but adjusted at various points does not seem to us to be sustainable. While intended to promote local ownership it does not, in practice, achieve this and **we believe that decisions on the number of commissions for basic training for non-medical staff each year should explicitly be taken centrally, based on local information.** This would align the decision-making process with that for medical students, where decisions on numbers are taken centrally.
- **To plan post-basic professional training and other staff training requirements within the area where joint planning is of value.**
- **To contract with local education providers for undergraduate and postgraduate education – this should include purchasing, monitoring and general liaison.** There are difficulties with purchasing training for some smaller groups at education consortium level at present and this might also be the case for Confederations. This may need to be undertaken nationally but **we would welcome views.**
- **To provide a focus for the development of human resource strategies where these are appropriate at an above-employer level** – for example recruitment and retention of professional staff; reduction of wastage in training; rotation and secondment opportunities; flexible working schemes which require more than one employer to be effective.

5.22 In addition we consider there may be scope over time for discussing with the relevant employers the role the new Confederations might play in workforce planning in the social care field given the increasingly close joint working between health and social care and the new partnership arrangements.

5.23 These new Confederations should be developed from existing education consortia and build on consortium best practice but **we believe that at present there are more consortia than can be sustained in terms of the skills available to them and the job to be done.** We do not wish to be prescriptive on the number of new Confederations which should be established and **we recommend that NHS Executive Regional Offices and Health Authorities should review the current pattern of consortia against defined criteria to determine the most appropriate configuration of Confederations.** In coming to final decisions on the number of Confederations it will be important to ensure that they are large enough to make use of economies of scale e.g. for purchasing education and training while remaining small enough to be sensitive to local labour market issues. They also need to be inclusive of all local health and social care employers.

5.24 The new Confederations should be responsible for workforce development issues for all clinical staff including doctors and dentists and as such **we recommend that they should subsume the current functions of LMWAGs**. It will be important, of course, that there is proper medical input, including from postgraduate deans, to the work of the Confederations but we do not believe that a separate medical advisory machinery is appropriate in the more multi-disciplinary world we envisage. Any LMWAG residual functions not appropriate to Confederations should be picked up at Regional Office level.

5.25 If Confederations are to operate effectively they will need:

- **Top management leadership, from a Health Authority or NHS Trust Chief Executive, who should be accountable to the Regional Office for the effective discharge of the Confederation's work and for the delivery of its commissioning plans, with proper full-time senior management support, including HR support.**
- **Adequate resourcing and support to enable them to undertake their work effectively.** We believe that the smaller number of Confederations we recommend, and the reduced amount of micro-planning which our recommendations entail, will release resources for this purpose but these may need to be increased, and funding should be made available for this purpose when necessary.
- **The full-hearted involvement of local employers, both within and outside the NHS, at a senior level.**
- **Good quality technical planning skills including skills in scenario planning.**

Over time they might develop into a source of support and expertise for local health economies and it will be important that they have the capacity and capability to take a strategic approach to their work.

National level

5.26 We have already indicated that at national level there should be a National Workforce Development Board and have set out its broad functions. The board would be supported by Care Group Workforce Development Boards whose functions were set out earlier in this chapter. These arrangements are intended to bring together workforce planning for clinical staff in a coherent way, looking consistently across primary, secondary and tertiary care. There are, however, other functions which we believe need to be undertaken at a national level.

5.27 First, **we believe there will be a continuing need for an additional group, reporting to the National Board, to look at future consultant and GP requirements and make recommendations on the number of Specialist Registrar and GP Registrar posts required, drawing on the proposals from Care Group Workforce Development Boards. We also believe that this group should be responsible for postgraduate planning for other clinical staff.** This group, which would be a successor body to SWAG, might sensibly bring together the chairs of the Care Group Workforce Development Boards and other key stakeholders, including NHS management and professional bodies. **We believe that its processes should be streamlined and reformed** so that it operates in a way which is more readily understandable to the NHS and other stakeholders. More work needs to be done on the interface between professional and care group planning in this area to ensure that the right balance is struck between professional needs and service requirements.

5.28 Second, we believe **a group, again reporting to the National Board, should be established to determine the overall number of undergraduate training places required annually in clinical professions** drawing on both local views and national expectations. This group might also commission work to consider the longer-term requirements for staff across all professional groups, building on and subsuming the work of MWSAC. There is a need for further work to develop these proposals fully, involving all those with an interest in these issues.

5.29 Third, there is a national responsibility, to be discharged through Regional Offices, **to performance manage the delivery of local and Confederation plans**. It is important that workforce issues are mainstreamed in performance management terms and that NHS Trusts and other players are held properly to account for delivering the changes they commit to. Similarly Confederations must be held to account for delivery of the training and education plans they agree in terms both of the numbers and types of trainees and of the effective use of resource. They must also be held to account for delivering their share of basic professional trainees in clinical professions other than medicine or dentistry and for other workforce development initiatives.

5.30 Regional Offices also have a role to play in **providing input to the development of national workforce policies and ensuring these are properly disseminated locally**. To deliver this **we recommend that each Regional Office should appoint a Director of Workforce Development** whose remit would encompass the current role and responsibilities of Directors of Education and Training but be widened to cover all aspects of workforce planning and development.

5.31 In addition to contributing to national workforce planning and development, perhaps through chairing Care Group Workforce Development Boards, these Directors would be responsible for:

- **Disseminating national policy development and thinking to Confederations and local NHS employers** to ensure that local service and workforce planning is properly informed (and conversely that national thinking is informed by local aspirations and initiatives).
- **Reviewing Confederation plans at Regional level to ensure consistency and coherence for transmission to national level.**
- **Working with postgraduate deans and Confederations to establish training posts for medical and dental trainees and clinical placements for trainees in other clinical professions.**
- **Allocating funding for training and education to Confederations.**

5.32 It should be for the Directors of Workforce Development to determine the most appropriate support arrangements, including both management and professional input, for their work, but **we do not believe this should necessarily be through Regional Education and Development Groups as currently constituted**. We do, however, see an important and continuing role for postgraduate deans and their deanery support. They will, as now, have a central role in the planning of postgraduate medical and dental education, in ensuring the delivery of postgraduate medical education to the standards set by the STA and the Colleges and in approving training posts. We would see them taking on an enhanced role in the planning of the medical workforce for non-training grades and in linking across to workforce planning for other clinical professions to ensure that an integrated approach is taken forward. We believe that the deans will need to operate effectively at both regional and Confederation level in order to do this. To assist in this **we believe it would be helpful if the boundaries of deaneries were aligned with Regional Offices. We would also expect deans and their Directors of Postgraduate General Practice Education to work to Directors of Workforce Development to ensure that planning at local, Confederation and national levels was each informed by the other.**

Information issues

5.33 If workforce planning and development is to be effective there will be a need for high quality, relevant and timely information on the workforce. This will entail significant changes to the current information base, in particular to provide routine information on staff involved in different care groups. At present there is only limited such information – medical and dental staff are analysed by specialty and there is some analysis of nursing staff by care group – but it is not available for all staff groups or for all care groups. Education consortia and some LMWAGs also collect information locally for their own requirements but there is no consistent data set at this level. In the medical and dental area we are concerned about the proliferation of data sets used for planning purposes. This can only lead to confusion and fruitless debate on the figures. **We believe there should be a**

single, agreed, dataset for clinical staff for use by the new Care Group Workforce Development Boards, by the successor body to SWAG, by the group considering annual requirements for undergraduate training and by Confederations.

5.34 We are conscious of the cost to the NHS of collecting information and particularly of changes to information collected. We are also aware that there have been a number of abortive attempts to agree data requirements for workforce planning, the most recent of which has been put on hold by our review. However we believe that change in the workforce information area is vital if the changes which we propose are to be effective. **We therefore recommend that, once agreement has been reached on the new planning systems which we have proposed, and particularly the care groups, there should be an urgent and comprehensive review of existing workforce information with the aim of developing a robust dataset to support new planning arrangements and making it widely and readily available to all users.** As part of this work consideration should be given to ensuring that data are available in a timely fashion – we believe that an increased emphasis on workforce issues at all levels will help to overcome the often tardy submission and analysis of information.

Improved training, education and regulation

5.35 **We believe it is important to build on and develop partnership working with those providing education for the NHS workforce and the relevant regulatory bodies.** Higher education institutions and other education providers should be fully involved in developing workforce plans in local health economies, contributing their knowledge and expertise. The NHS should build on the willingness of the Committee of Vice-Chancellors and Principals (CVCP), shown in the establishment of a single Health Committee, to develop good working relationships to cover a range of inter-professional issues. In this **context we welcome the recent NHS Executive/CVCP Partnership Statement.**

5.36 **We believe it is important that the NHS, with the support of the CVCP, deans and others, should work with higher education providers and accreditation bodies to improve the flexibility of basic and post-basic training programmes to facilitate career shifts during and after training.** Both those commissioning and those supplying education and training for healthcare employees should ensure that the impact of changes in healthcare are reflected in education to prepare students for a constantly changing future. In particular **it will be important that the higher education system can respond quickly to changing requirements both in terms of syllabus design, in terms of establishing courses to meet NHS needs and in terms of encouraging varied entry routes into higher education which put a premium on knowledge and experience as well as academic ability.** In this context **we believe the changes set out in the nursing strategy *Making a Difference* which encourage more flexible entry routes into professional training will be helpful.** In particular higher education providers will need to work closely with the NHS in designing appropriate training for new types of healthcare worker. It will also be important to build on current good practice and **develop training and education arrangements which are genuinely multi-professional and which will enable students to transfer readily between courses without having to start their training afresh.** Continued development of modular training will help here. **We would also welcome a further look at maximising part-time training opportunities to ensure the widest possible access into the health professions.**

5.37 Delivering this will require close working and constant dialogue at both national and local level so that all parties can contribute to the development of genuinely joint working. Such dialogue should help to overcome the concerns expressed to us that training requirements were dominating service provision, and yet that training does not always deliver staff with the skills the NHS requires. The regulatory bodies need to be involved in this dialogue and to work closely together to ensure a consistent approach to regulation which allows staff to practice their skills effectively. More generally, increased use of joint appointments between the NHS and universities should help staff to maintain awareness of the needs of both sectors.

5.38 The NHS funds basic education for a range of clinical staff including nurses. We are concerned at the variation in the costs of such education and at the risks to some institutions which arise from their dependence on the NHS. We do not believe the latter is healthy or conducive to attracting the highest-calibre teachers. We accept that the arguments are complex in this area and that although bargaining power is certainly a factor, particularly in geographical areas where there are monopoly or near-monopoly suppliers, there are other drivers for cost variation including volume of students; type of HEI (older universities tend to be more expensive because of their higher superannuation rates); whether the contract was tendered to get maximum value for money or simply rolled forward; and the inclusion of teaching accommodation costs which can be a distorting factor. We welcome the move to obtain better quality data which strip out distorting factors to enable true comparisons to be made. **However, we believe more needs to be done. In particular, we are aware of work in hand to address price variations and believe that this should be pursued vigorously with consideration being given to establishing benchmark prices. We also recommend that the NHS Executive and the new Workforce Development Confederations should seek to place longer term contracts with education bodies.** In return for a greater certainty of long-term income we would expect to see both reductions in prices charged by providers and more flexibility in contracts to ensure that they match changing NHS requirements. In developing new approaches to contracting **we also consider that Confederations should look to move away from contracting on an input basis and take account of attrition rates in training and successful completion of training, without compromising quality and other standards, in agreeing contract prices.**

5.39 We are conscious of continuing difficulties in recruiting and retaining high quality teaching staff in a range of professions and that there are particular concerns about the position of academic medical staff. This is a long-standing issue and has a range of causes but we are concerned that, as the number of medical students increases, there should be adequate staff available to teach them. We are aware that a joint DH/Joint Consultants Committee symposium on Careers in Academic Medicine was held in October 1999 to review the current position and to suggest solutions for outstanding problems. An ad hoc group – the Dental Schools and Hospitals Priorities Group – has addressed the same issues for dentistry. We are also aware of a recent report from a working party of the Academy of Medical Sciences on recruitment into clinical academic medicine. We recognise the importance of these issues and **we welcome the action that is being taken forward by the Academic and Research sub-Committee of AGMETS following the symposium.**

5.40 We noted that there are problems in establishing adequate clinical placements for nurses and other clinical staff in training and in establishing Specialist Registrar posts in some specialties. A range of reasons was given for this, including difficulties in ensuring adequate supervision and, in the case of medical posts, the lack of service benefit from trainees for whom a NHS Trust had to meet half the salary cost. It is short-sighted of NHS employers not to participate fully in the training of staff. Without proper provision for training the service will lack the numbers of fully-trained staff required to provide care for patients. **We believe the new Confederations should have as an integral part of their work programme ensuring that clinical placements are available for those requiring them. Individual employers and Confederations should be accountable to Regional Directors of Workforce Development for providing sufficient good quality clinical placements to ensure the delivery of agreed plans.** In the case of small specialist staff groups there may need to be consideration of innovative funding approaches.

5.41 In the case of Specialist Registrar posts, Confederations and postgraduate deans should work closely to identify such suitable training posts to meet the recommendations of the successor body to SWAG. To help with this **we believe there needs to be greater flexibility in the balance between NHS Trust and levy funding for these posts.** While the current 50:50 funding split for basic salaries has attractions it can lead to problems and hinder creative solutions. We are aware that in Scotland posts are 100% levy-funded and similar arrangements apply to posts in public health medicine in England. While there are attractions in this approach we are not convinced that it is right in all cases given that NHS Trusts benefit from service support from the majority of staff in training. Rather **we believe that there should be flexibility for Directors of Workforce Development and Deans to vary the levy contribution, both upwards and downwards, in order to ensure that good quality training posts can be established.** We would expect variations to be used with discretion, it would clearly defeat

the aim of establishing more posts in specialties where there is little service benefit, at least in the initial years of training, if all posts were to be funded predominantly from the levy. Such an approach would also reduce the number of posts that could be funded from the available resources. **We believe, therefore, that a clear framework should be established for using the proposed flexibilities.** Changes in the level of support NHS Trusts receive from the levy will need to be made cost and activity neutral.

5.42 We are also aware that there have been occasions where medical Royal Colleges have sought to remove accreditation from training posts, an action which is in law the responsibility of the STA for doctors and the GDC for dentists. In some cases the removal of accreditation would have had a devastating effect on service provision. In other cases the developments needed to meet College requirements run counter to service priorities – in one Trust they would have required the appointment of a fourth plastic surgeon rather than a second, much-needed, cardiologist. **We do not believe it is acceptable for any body to remove training accreditation without proper discussion and consideration, not least of the service implications of such an action. We recommend that there should be early discussion between the NHS Executive, NHS managers, the STA and the Royal Colleges to establish an agreed procedure for responding to concerns arising from College visits.**

5.43 As indicated earlier, **we believe that an integrated approach to levy funding, combined with proper support from NHS Trusts for training other staff, will enable a more effective training provision to be delivered.** The underlying aim should be to use the resources which the NHS puts into training and education to lever change rather than to reinforce existing practice. To this end **we believe that NHS Trusts, in developing strategies for continuing professional development and lifelong learning, should gear their thinking and resourcing to supporting greater career flexibility and the development of additional skills for staff.**

5.44 While not directly the responsibility of our review, we were concerned at the high wastage rates of trained clinical staff – other than doctors and dentists – from the NHS, including the loss of staff immediately after training. This is of particular concern where the NHS has fully funded training. We welcome work being taken forward in the Department to improve retention rates but believe there is more to be done. Retention of staff should be high on all managers' agendas. Retention and returner schemes need to be further developed and applied to all staff groups – good schemes in general practice and management should be built on for other groups. More work needs to be done on how these fit into time-limited training schemes. **In addition, however, we wonder whether there could not be a mutually beneficial new relationship between the NHS and those clinical staff who have received NHS-funded pre-registration training. In exchange for committing to work for the NHS for a defined period of time, the NHS in return would guarantee to employ the individual member of staff for that same period of time subject, of course, to satisfactory performance.** We are also concerned that generally there is no support from the private and voluntary sector for training costs, and that in some cases where the private sector has sought to subsidise training this has not proved possible. **We believe that this should be reviewed.**

5.45 Finally, we are clear that working patterns for healthcare staff are likely to continue to change and there will be increasing need for flexible training and flexible employment arrangements. We believe work needs to be put in hand urgently to support staff through change. A more structured approach to counselling and mentoring staff will be needed particularly to help staff adjust to new roles and new requirements. We welcome the work which has been taken forward by the NHS Executive's Recruitment and Retention Unit under the banner of Improving Working Lives. However we believe more remains to be done, particularly to integrate initiatives for the medical workforce with those being taken forward for other staff groups and **we recommend that there should be a single focus within the NHS Executive for this work. We also believe it is important that the NHS Pension Scheme keeps pace with the needs of a changing workforce and gives scheme members increased flexibility and choice.**

Staff numbers and career pathways

5.46 We mentioned earlier that England has fewer doctors per head than many other Western countries. While staff numbers are not everything – there are issues about how efficiently and effectively staff work – there is, as the Secretary of State has said, a need for more doctors in the NHS. **We believe the time is right, therefore, to consider the numbers of fully-trained medical and dental staff required in the long-term.**

5.47 We do not, however, believe it would be right for medical workforce requirements to be considered in isolation. **We believe therefore that the numbers of professional staff other than doctors and dentists required to deliver the services which Ministers want to see in place should be reviewed both now and regularly in the future through the mechanisms we have proposed.**

5.48 Current shortages of doctors, nurses and other professional staff are the legacy of past under-training compared with numbers which were required by the NHS and other employers. This has led to a continuing heavy reliance on overseas-trained staff, a position which may not be sustainable in the long-term and may be detrimental to the delivery of health care in their own countries. **We believe that over time, as we move towards greater self-sufficiency, proper consideration should be given to the costs and benefits of training more staff than might technically be required in order to provide a safety margin against future changes in demand.** This is the case in many other professions where career paths are sufficiently flexible to allow for the use of professional expertise outside conventional practice.

5.49 As well as reviewing staff numbers we believe it is important to ensure there are clear and flexible career structures and pathways for staff in the NHS.

Nurses, Therapists, Scientists, Pharmacists and other staff groups

5.50 Work has already been put in hand to develop new human resource strategies for nurses, PAMs and scientists and technicians. *Making a Difference* is the most comprehensive strategy ever produced for improving the status, training and job opportunities for nurses, midwives and health visitors. It launched proposals for a new model of nurse education and a stronger role for the NHS in the better management of NHS funded education which will be taken forward by the establishment of a new, multi-professional, education and training unit within the NHS Executive.

5.51 From September 2000 a new model of nurse education will commence in sixteen partnership sites. This will introduce more flexibility in nurse education with “stepping on and off” points at the end of year one, an outcomes based approach and fast tracking into year one of the programme. In particular these reforms will, through Accreditation of Prior Learning and Experience (AP(E)L), mean that non-professional staff will be able to access professional education utilising previous knowledge and experience, e.g. through the attainment of NVQ level 3 and be able to fast track into the nurse education programme. New local cadet schemes will also operate from September 2000. These schemes will offer a vocational pathway into nurse education as they result in the award of vocational qualifications. We welcome these approaches and also support the further exploration of ways of opening up vocational access to nursing programmes for existing and future support workers.

5.52 A parallel strategy is currently being developed to strengthen the contribution and influence of PAMs. It will highlight the crucial part they play in delivering the Government’s modernisation plans for the NHS and social care by leading partnership working across professional boundaries. It will also recognise the need to expand and secure a high quality workforce for these professions; to provide improved career opportunities and recognise clinical expertise; and to encourage improved diversity across the professions.

5.53 The National Advisory Group for Scientists and Technicians (NAGST) has developed a work programme to ensure that scientists and technicians are fully assimilated into the overall human resources strategy for the NHS workforce. The main objective for NAGST is to create an employment environment that is attractive and

supportive for NHS staff, that will enhance career progression, and that will improve recruitment and retention. As part of this it is developing the knowledge base to inform effective workforce planning. It is also looking to develop an Occupational Standards Framework for the entire scientific and technical workforce on which competency development and assessment can be based. Both programmes should help to consolidate the professional groups within this sector and should also facilitate the formation of links with Higher Education Institutions.

5.54 The demand for pharmacists to support the developing prescribing and medicines management agenda continues to grow. Work is in hand to tackle recruitment and retention difficulties, including the impact of the move to a four year pharmacy degree. The intention is to build on this work to recognise the clinical expertise of pharmacists, to enhance career opportunities and to ensure that there are sufficient pharmacists with the necessary skills to meet the needs of primary and secondary care.

5.55 We are also aware of current discussions with the Joint Royal Colleges Ambulance Liaison Committee on the future role and education of paramedic ambulance personnel. We believe that these will provide the impetus to ensure that future arrangements for paramedics will provide a skilled and trained workforce playing their full part in a modern NHS.

5.56 However we are also conscious that a number of staff groups, such as Operating Department Practitioners, who perform critical roles in service delivery, currently sit outside mainstream workforce planning and funding arrangements. It is important that their training and development needs are properly identified and considered.

5.57 **We welcome the initiatives which are currently taking place and believe they can and should be built on. These professional developments will, however, only deliver fully if they are set in the context of an approach to workforce planning and development which is firmly based in the services to be delivered and the skills needed to deliver them.**

Hospital medicine and dentistry

5.58 Turning to the medical and dental professions, we believe there will be an increasing requirement for services to be **delivered** by fully-trained medical and dental staff, with appropriate support from trainees and service staff. In our view the pressures in this direction, from the quality agenda, from clinical governance and from patients will be irresistible. Action is already being taken in this area. In recent years there has been a substantial increase in consultant numbers – an average of 4.9% per annum for the last five years – and sufficient Specialist Registrar places exist to support further growth of some 6% a year over the next five years. **We believe there will be a need for a continuing increase in the number of fully-trained medical and dental staff but this will need to be accompanied by changes in the traditional way in which they work.** In particular more of the service delivery out of hours as well as during the day will need to be provided by fully-trained staff. We recognise that this will be controversial but we consider that it is both inevitable and right.

5.59 We know that changes to the working pattern of consultants have been discussed within the medical profession and elsewhere over the years and that changes have occurred in some places. For instance we heard examples of consultants being resident on call over night and off duty the following day. One option to deliver the change we believe to be necessary would be to build on this and to look to negotiate appropriate changes to the consultant contract and job plans which would make such an approach common practice. Another approach, **and one we believe requires serious consideration**, would be to establish a new specialist grade which would be staffed by fully trained doctors and dentists who would work alongside consultants and be appropriately remunerated. Nor, of course, are these mutually exclusive.

5.60 Specialist posts might more easily be part-time, or take on a heavier element of clinical work to build experience. They might be final stopping points in a career, or en-route to a consultant post. Doctors in the new specialist grade would not work under the clinical supervision of a consultant but would supervise the care of patients in their own right and may work as part of consultant teams (see below). There is a range of ways in

which specialists might work and it is important to build in flexibility. In some specialties specialists and consultants might work alongside each other with the only distinction being that the specialist took more of the clinical load. In other cases they might share work according to its nature. The important point is that there should not be a new hierarchy but rather a team working approach aimed at delivering more care by fully-trained doctors and dentists to the benefit both of patients and of trainees, who would be able to concentrate more fully on learning their profession rather than being expected to be major service providers as well. Apart from the more general benefits it would bring **we believe that this approach, together with a system of mentoring for newly appointed specialists and consultants, would help to tackle the expressed concerns about the impact of the Calman reforms.** We are aware that an evaluation of the new Calman training arrangements is due to report later this year and we believe that this should be considered fully as part of future developments.

5.61 Moving in this direction has a number of implications. First, the job descriptions and job plans of such specialist staff would need to be flexible, and attuned to the needs of the employing NHS Trust.

5.62 Second, the patterns of more senior consultants work may well change with probably less in-patient care and more emphasis on out-patient care, teaching, training, mentoring and management. This would require consultants and specialists to work as teams sharing a patient's care between them, rather than the more traditional approach of one consultant giving all a patient's care. This would be similar in some ways to group practice in primary care, and already operates in some hospital teams.

5.63 Third, there would be a need for NHS employers to commit to employing the new specialists appropriately. Further consideration needs to be given to the mechanisms for achieving this.

5.64 Furthermore, in the longer term, there will need to be a significant reduction in the number of specialist trainee posts as the number of fully-trained doctors increases and we reach "steady state" in terms of the numbers of fully-trained staff required to deliver care. We will then be in a situation of only needing to train sufficient doctors and dentists to replace those who retire or resign, and to support more modest growth than is currently planned for. While this position may be some time off we need to consider it now given the long lead-time for medical and dental training. This will drive the need to consider alternative career paths for doctors. **We believe that three major changes are needed here.**

SHOs

5.65 First, the SHO grade is widely seen as a problem area, with trainees providing an undue service commitment and large numbers of staff in a training grade who are not in reality in training at all. Furthermore there is great pressure on staff to race through the grade as quickly as possible both because it is seen as an unpleasant part of a doctor's career and because of the intense competition for Specialist Registrar posts. **We believe that steps need to be taken urgently to sort out the SHO grade and manage the basic education and training of our doctors better.**

5.66 SHO posts should be used to ensure breadth at this stage of a doctor's career, reducing the possibility of a hasty career decision. Workload should be better managed – something which will be necessary to deliver the reductions in working hours required by the Working Time Directive. In addition a review of the tasks undertaken by SHOs should enable some of the work to be done more appropriately by others (other medical staff, other clinicians, such as nurses or therapists, or workers such as the proposed "physician's assistant") who can use their skills and abilities more effectively to the benefit of patients. The underlying aim should be to ensure that we do not employ more doctors as SHOs than are required for training purposes simply to meet service needs.

5.67 While we believe that time in the SHO grade should be sufficient to provide broad training – including increasingly a period of training in general practice – SHOs should not remain indefinitely in training posts when they will no longer benefit from them. Progress through the grade might be related to the achievement of milestones rather than serving particular periods of time, enabling SHOs to move at their own pace. A corollary to this would be that those selecting staff for Specialist Registrar posts should be encouraged to respect breadth of training and a range of skills as much as single-minded dedication to a particular specialty. We also believe that more structured training programmes, clearer appraisal arrangements and the provision of properly structured alternative career paths for those who are unable, or do not wish, to progress to Specialist Registrar training will be important.

5.68 **We are conscious that work has been taken forward on these issues in various fora but we believe the time is now ripe for action.** As part of this work **we believe that we should consistently use the term “doctors in training” rather than “junior doctors” for those staff in the PRHO, SHO and Specialist Registrar grades.**

Non-consultant career grades

5.69 A significant number of doctors and dentists with varying qualifications and skills are employed as staff grades, associate specialists and in NHS Trust-specific grades. They provide service support but are often overlooked in terms of career progression, training and development and continuing education. We are concerned that the number of such doctors has increased significantly in recent years in an unplanned way, often in response to short-term problems. While there will continue to be a need for such staff in the future **we believe that, as with other staff, posts should be properly planned and linked to service plans. We also believe that steps should be taken to provide a proper career structure for such staff, which will see them as providing a valuable and valued role within the hospital and community health services.**

5.70 In particular we see it as important that there is scope for staff in specialist training to step out of training posts and undertake a period in service posts and then return to the training ladder, and for staff who are employed in service posts to have better opportunities to re-enter training.

Reskilling

5.71 We accept that the increased specialisation of the medical workforce is probably an irreversible trend and that there are benefits in terms of quality of care to patients. However we are concerned that young doctors appear to be under pressure to specialise in a particular area very early in their career. Decisions about specialties can be made on very flimsy grounds, based on previous role models or experiences that may not have been sufficiently broad. **We believe that the broader general training which we recommend above will help here. However, we also believe that the STA should be asked to look at the scope for developing retraining packages for Specialist Registrars and experienced consultants who wish to retrain in another specialty without requiring them to commence training at the bottom of the training ladder, where their previous training was appropriate and relevant.**

5.72 To assist in this **we believe there needs to be improved career counselling and support for doctors in training and for other staff who are considering career options both during basic training and, as importantly, subsequently.**

5.73 Delivering the changes we suggest above will not be easy and will require considerable discussion with the medical profession and other groups. We were encouraged in our discussions by a growing recognition that change was needed and **we recommend that early discussions are held between the NHS Executive, NHS management and the medical and dental professions to implement changes on the lines we suggest.** In doing this it will be important to recognise that effective changes cannot be achieved by piece-meal initiatives and will require a “whole-systems” approach.

General Practice

5.74 **We believe there is a need for greater clarity about the future requirements for primary care and hence for GPs and other primary care staff.** At present GP numbers are planned to grow by 1% a year, broadly in line with historic trends. We recognise that workforce planning in primary care is developing but we are conscious that service developments are placing increased demands on general practice and that GPs would like there to be greater clarity in focusing on their clinical role. We are not convinced that historic growth rates will be adequate in future and **believe more work needs to be undertaken on future requirements for GPs.** We are also conscious that while the MPC has worked hard to ensure an equitable distribution of GP principals its role has been essentially a negative one in preventing GPs practising in particular areas. We believe that in future there may be a need positively to encourage GPs to move into particular areas in order to boost primary care to deliver Hlms, even where traditional measures such as list size suggest there are adequate numbers of GPs. Furthermore we are conscious that the MPC's task has been made more complicated by the variety of contractual arrangements under which GPs now work and the development of the primary care infrastructure. **The MPC is due for a quinquennial review in 2000 but we believe that consideration of its role needs to be set in the context of a more fundamental review of primary care workforce issues, taking account of the role of PCTs and other developments such as walk-in centres.** This should also be linked with reviews of workforce demands in primary care and skill-mix issues between GPs and associated staff, such as counsellors, social workers, nurses and therapists. There should also be better integration of planning for community pharmacist and optical professions in primary care.

General Dental Practice

5.75 The Government is committed to improving access to NHS dentistry. A dental strategy is shortly to be launched and **we believe that workforce issues should be considered as part of the plans for implementing that strategy.**

Conclusion

5.76 Our proposals and recommendations set out a major programme of action for the NHS, its partner organisations and the NHS Executive. **We believe that if they are to be delivered a properly resourced implementation team needs to be established to drive through the changes and to provide support and assistance to help the change process.** The level of change required is significant and is not just about new projects that need funding, or new decision-making structures. It is a key part of the culture change that is taking place in the NHS as Ministers seek to modernise it to meet patients' demands. The implementation team will need to work at all levels to achieve a new approach to workforce development, and hence the goal of having the right staff with the right skills in the right place at the right time.

5.77 **We also believe that as part of the implementation of these changes the NHS Executive HQ should look at whether it is appropriately structured and resourced to support the new workforce development arrangements we propose.** It is not clear to us that it yet has a fully integrated approach itself or that it has properly brought together service, financial and workforce planning, though we recognise that significant changes have been made in recent years. However it will not be appropriate if the watchwords of integration and whole systems are not seen to apply to the centre as much as to the NHS.

5.78 We believe that there is no time to lose in implementing these changes if the NHS workforce is to be in a position to deliver the major changes to the NHS which Ministers wish to see.

How to comment on this consultation document

6.1 Ministers would welcome views on the proposals and recommendations in this consultation document. They should be sent to:

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Quarry Hill
Leeds
LS2 7UE

Fax Number: 0113 2545866

Email address: MB-Workforce-Planning-Review@doh.gsi.gov.uk

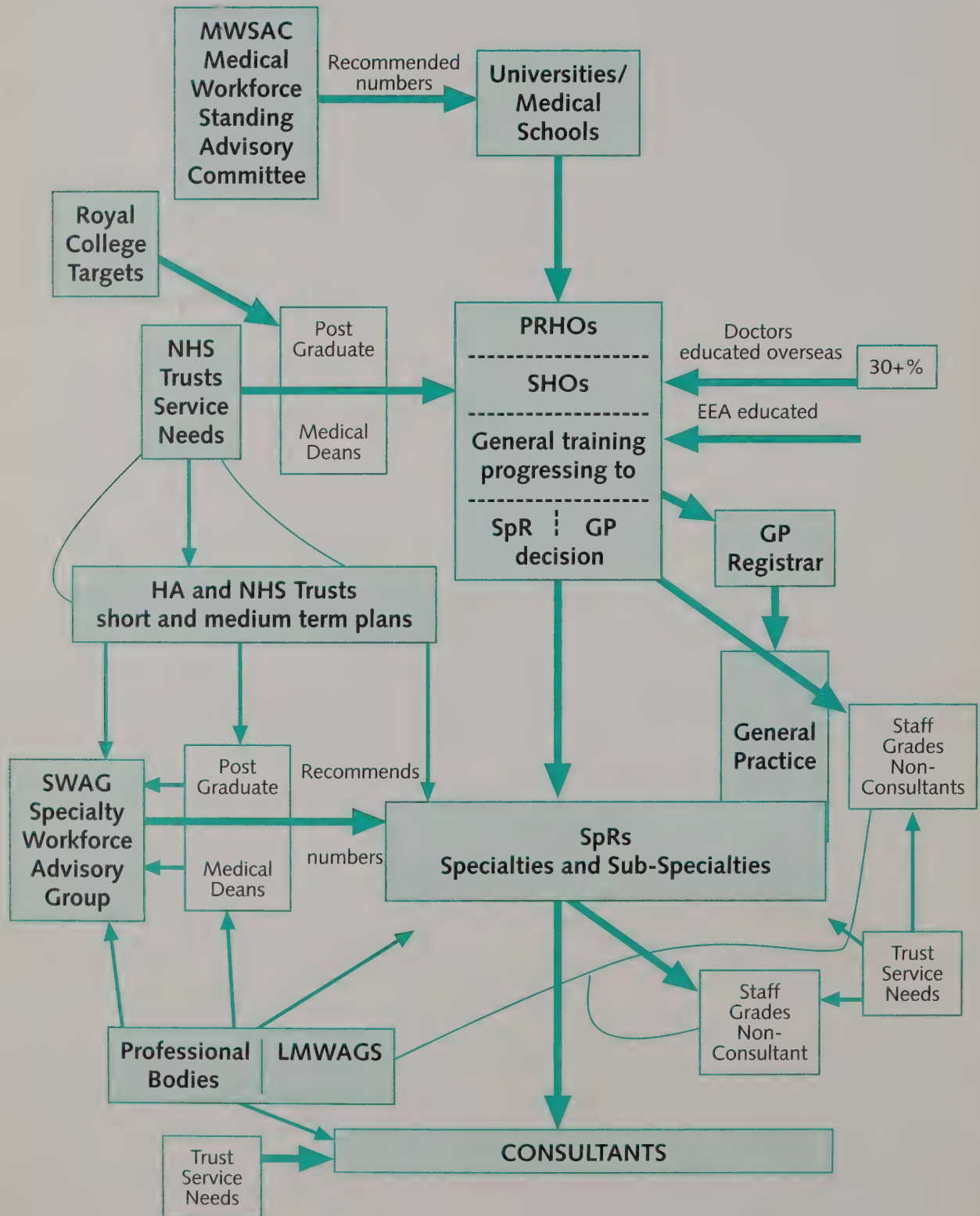
by **16 June 2000**.

The consultation document is available on the internet at: www.doh.gov.uk/wfprconsult

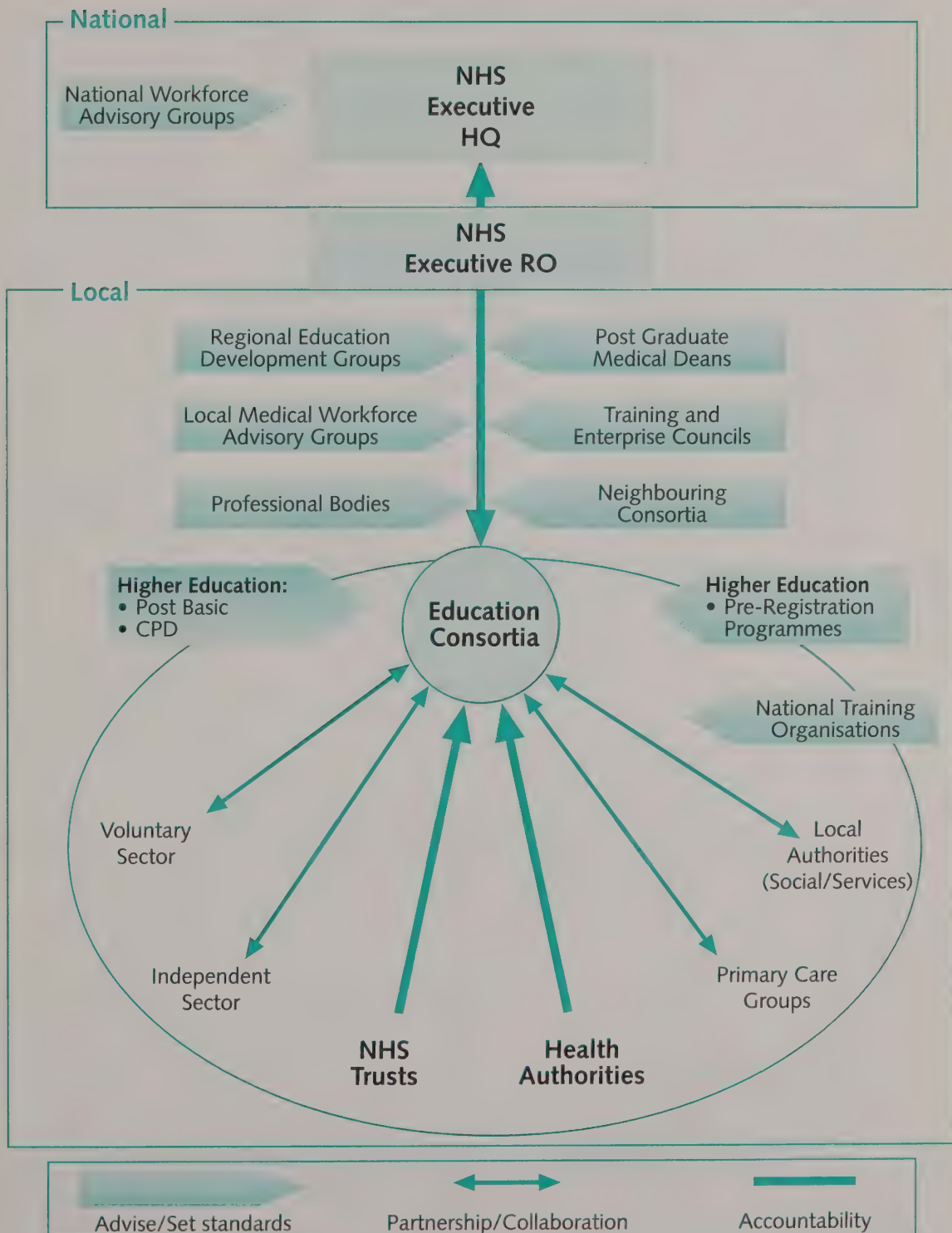
6.2 As part of the consultation process a series of Regional workshops will be held to discuss the proposals in the document. Further details are available from Ian Mallett as shown above.

6.3 Responses to this consultation document will normally be made available unless they are confidential. Please tell us if you want your response to be confidential. The outcome of consultation will be published and followed by an action plan.

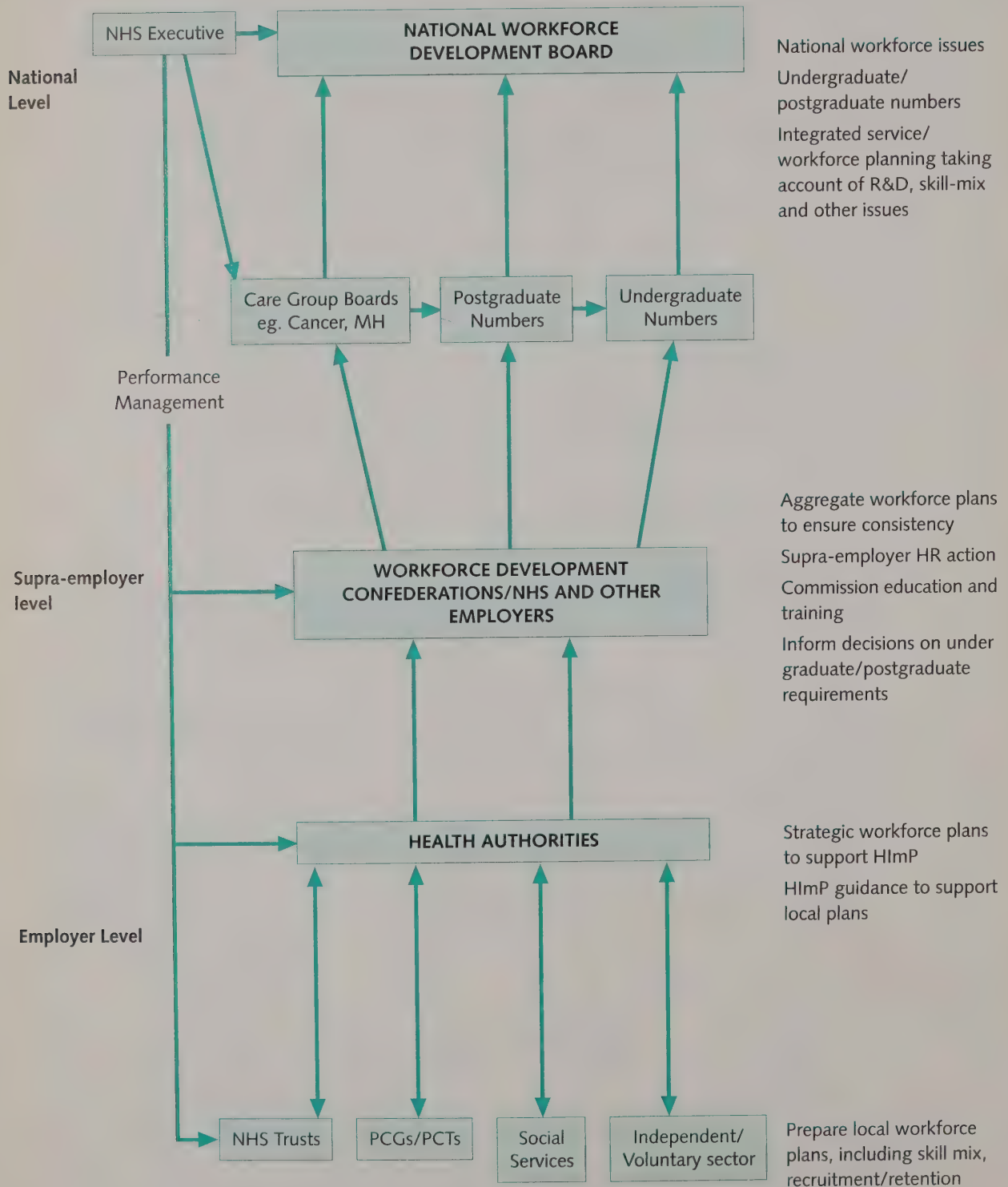
Current medical workforce planning arrangements



Current workforce planning arrangements for other clinical staff



Proposed workforce planning arrangements





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